Supporting a Healthy Home

An Analysis of Opportunities and Barriers to Medicaid for Permanent Supportive Housing Providers in Illinois

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Table of Contents

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ACRONYMS AND TERMS

ACA	Affordable Care Act
CMS	Center on Medicaid Services (federal)
DASA	Illinois Department of Human Services' Division of Alcoholism and Substance Abuse. Has jurisdiction over Rule 2060 and Rule 2090.
DMH	Illinois Department of Human Services' Division of Mental Health. Has jurisdiction over Rule 132.
HFS	Illinois Department of Healthcare and Family Services
IDHS	Illinois Department of Human Services
MCO	Managed care organization
Medicaid-billing PSH provider	PSH providers who have gone through the requisite steps of becoming licensed and/or certified to provide Medicaid billable services, and enrolled with HFS to become a Medicaid provider
PSH	Permanent supportive housing
Rule 132	Part of Illinois's Administrative Code governing the delivery of mental health services through Medicaid.
Rule 2060	Part of Illinois's Administrative Code governing the delivery of alcohol and substance abuse services.
Rule 2090	Part of Illinois's Administrative Code that contain the standards for billing Medicaid for alcohol and substance abuse services.

EXECUTIVE SUMMARY

Permanent supportive housing (PSH) is affordable housing paired with supportive services designed to enable residents, often those at risk of homelessness or who have serious mental illness or other disabilities, to live in the community and achieve long-term housing stability.

Permanent supportive housing has been shown to improve the health of residents, many of whom experience complex health conditions, as well as reduce their health care costs. Funding for PSH, particularly for the supportive services they offer, is seriously threatened in Illinois. Medicaid funding is one option for funding supportive services that improve health outcomes for PSH residents, and new opportunities are arising that would make it easier for PSH providers to access Medicaid. Increasing access to Medicaid for supportive housing providers would not only help PSH providers keep their doors open, but would improve the health of some of the hardest-to-serve and most vulnerable healthcare consumers.

This study uses surveys, interviews, and policy research to document barriers to accessing Medicaid for PSH providers, describe organizational capacities necessary to become a Medicaid biller, and provide lessons learned from PSH providers that have gone through the process of becoming certified to bill Medicaid. In addition, the report makes recommendations for changes to policy and practice that would expand access to Medicaid for PSH providers in Illinois.

SUMMARY OF FINDINGS

The study finds that significant barriers exist for PSH providers that are interested in becoming certified Medicaid billers. Many PSH providers lack the organizational capacities, such as administrative and clinical staff, electronic medical records and billing software, and requisite policies and procedures, to handle the burdens of administering Medicaid-billable services. Medicaid-billing PSH providers report that the process of becoming certified is confusing and complicated, including enrolling as a biller with the Illinois Department of Healthcare and Family Services' online enrollment system, IMPACT. Medicaid-billing PSH providers also note that it is difficult and expensive to comply with Medicaid's billing and documentation requirements—some of which vary across Managed Care Organizations (MCO). Many PSH providers—both Medicaid billers and non-Medicaid-billers—believe that Medicaid will be integral to funding supportive services going forward as grant funding is threatened. There are also promising possibilities for partnerships between Medicaid billers and non-Medicaid-billing PSH providers that could result in better health outcomes for PSH residents and diversified funding streams for PSH providers that do not have the capacity to bill Medicaid.

KEY FINDINGS

The study found:

- **Using Medicaid to pay for the supportive services they provide to their tenants is of great interest to permanent supportive housing providers**. 85 percent of survey respondents are currently a Medicaid biller (50 percent) or have considered becoming a Medicaid biller or partnering with one.
- **There are significant barriers in place to becoming a Medicaid biller.** Administrative burdens and lack of clarity around the process are common factors that discourage PSH providers from pursuing Medicaid certification or partnerships.
- A number of **organizational characteristics** emerged from the surveys and interviews as capacities necessary to becoming a Medicaid biller or barriers to accessing Medicaid:
    - **Size**—some providers that bill Medicaid believe that there is a size threshold at which it becomes worth it to take on the burdens of becoming Medicaid biller, and the survey data show that Medicaid billers tend to be larger on average than non-Medicaid billers.
    - **Clinical staff**—Medicaid regulations require that organizations that bill Medicaid have clinical staff on hand to provide the billable services (or supervise the staff that provide services). This can be a barrier to accessing Medicaid for permanent supportive housing providers if they do not have clinical professionals on staff already, since their salaries are often higher than case managers or other staff typically at PSH providers.
    - **Electronic medical records and billing capacity**—PSH providers that become Medicaid billers often must overcome both technological and staff capacity hurdles when it comes to adopting electronic medical records and billing Medicaid appropriately.
    - **Administrative staff**—In addition to the technology and training costs of enacting new administrative procedures, many PSH providers that become Medicaid billers need to hire new administrative and compliance staff with experience in billing Medicaid.
    - **Varied funding**—Medicaid will not reimburse direct housing costs, so PSH providers will always need alternate funding sources to cover those substantial costs.
    - **Quality assurance procedures**—Becoming a Medicaid provider often involves adopting new quality assurance procedures for PSH providers, which requires extensive staff training.
    - **Housing model**—The structure of a PSH provider's

housing—whether it is in a single site or scattered site—affects how easy it is to deliver Medicaid billable services to their residents. Just a third of PSH providers that only have scattered-site housing are Medicaid billers, compared to 43 percent of single-site providers and 70 percent of providers that have both.

- In addition to the need to develop new organizational capacities to administer Medicaid, other **contextual barriers** make it challenging for PSH providers to access Medicaid:

    - **Medicaid reimbursement rates**: Many providers noted that the Medicaid reimbursement rates, particularly for psychiatry services, do not always cover the full costs of providing the services.

    - **The need to obtain two certifications to provide mental health and substance use services:** Many people at risk of homelessness grapple with both mental health and substance use disorders. Yet, to provide the full cohort of services addressing these commonly co-occurring issues, providers need to be certified separately to bill Medicaid through both DASA and DMH.

    - **Lack of information about completing the Medicaid certification and enrollment processes**: Many providers are unclear about what organizational capacities are required to become a Medicaid biller and how to get started and complete the process of enrolling as a Medicaid billers.

    - **Limitations in billable services**: In order for PSH providers with a linkage-to-services model to maximally benefit from Medicaid funds, Illinois would need to update its Medicaid rules to allow providers to bill for pre-tenancy or tenancy support services that PSH case managers often provide.

    - **Contracting with and obtaining prior authorization for services from Managed Care Organizations**: Medicaid billers must negotiate contracts with potentially dozens of MCOs in order to create a viable Medicaid program, each of whom has their own billing, payment, and administrative procedures, as well as standards for what services are billable to Medicaid.

- Lessons from Medicaid-billing PSH providers' experiences with the Medicaid certification process include:

    - **The time it took for providers to become a Medicaid biller was not typically too long**. Of the respondents who knew how long it took for their organization to become a Medicaid biller, 70 percent took less than 6 months.

    - Several providers noted that it would have been useful to receive **more intensive training or assistance** with the Medicaid provider enrollment process.

- To the extent that Medicaid-billing PSH providers had to incur costs in order to meet Medicaid requirements, **it was unclear whether those costs were sustained over time**.

- Of survey respondents, **most Medicaid-billing PSH providers said they were able to enroll with IMPACT by the original deadline** (63 percent). For those who could not, common barriers include technological errors and errors in Medicaid IDs and certification numbers.

- **Smaller organizations were more likely to be able to enroll on time with IMPACT than large organizations**. This may indicate the difficulty of having to enroll multiple sites through IMPACT.

- **Having smaller staff sizes posed challenges to enrolling in IMPACT.** Organizations with fewer staff may not have the administrative capacity to effectively navigate IMPACT.

- When Medicaid-billing PSH providers received training or assistance with IMPACT, they generally found it to be helpful.

- Medicaid-billing PSH providers reported that Medicaid has a range of impacts on their organizations—some positive, some negative:

  - Medicaid-billing PSH providers find that Medicaid helps them **diversify their funding streams.**

  - Most Medicaid-billing PSH providers use Medicaid funds to **shore up their existing operations**, rather than expand into new areas.

  - The **administrative burdens of billing Medicaid were substantial** for many Medicaid-billing PSH providers.

  - Despite the challenges posed by the administrative requirements, **most (62 percent) Medicaid-billing PSH providers recommend that other PSH providers become Medicaid billers.**

  - **A greater proportion of Medicaid-billing PSH providers provide clinical services** (including mental health, substance use, and primary care) through their organization than do non-Medicaid billers. Non-Medicaid billers are more likely to offer some non-clinical services than are Medicaid billers.

  - **Medicaid biller status varies by the PSH providers' geographic locations**. This geographic variation may be due to different PSH business models throughout the state; downstate, many PSH providers are integrated in medical systems, while some PSH providers in Chicago are primarily property managers or place residents in scattered-site units.

- The role of Managed Care Organizations strongly influences Medicaid-billing PSH providers' experience with Medicaid:

- Most Medicaid-billing PSH providers contract with MCOs (89 percent).

- In general, Medicaid-billing PSH providers found **the financial benefits of contracting with MCOs were worth the costs.**

- While managed care organizations are reimbursed for Medicaid services by the state via capitated rates, **MCOs in Illinois typically pay providers on a fee-for-service basis**, which creates complex administrative burdens for PSH providers.

- While the majority (53 percent) of Medicaid-billing PSH providers that contract with MCOs receive support from MCO care coordination staff, **it is still concerning that a third of them do not receive this support** when it is a central component of the managed care model.

IMPLICATIONS FOR POLICY AND PRACTICE

The trends that demonstrate a need for action to support services better serve the health needs of PSH residents, as well as for PSH providers to diversify their funding sources, demand that PSH providers, policymakers, and MCOs take action to ensure Illinois can leverage the opportunities and navigate the challenges that such a trend represents.

Implications for PSH providers include:

- Consider becoming a certified Medicaid provider.
- Explore partnerships with traditional health and behavioral health organizations.
- Invest in data systems.

Implications for policymakers and MCOs include:

- Reduce the challenges associated with becoming a certified Medicaid provider.
- Simplify billing and documentation requirements.
- Facilitate and incentivize innovative payment and delivery service models.
- Pursue a new Medicaid supportive housing benefit.
- Adequately fund existing PSH funding streams.

INTRODUCTION

Permanent supportive housing (PSH) is affordable housing paired with supportive services designed to enable residents, often those at risk of homelessness or who have serious mental illness or other disabilities, to live in the community and achieve long-term housing stability. Residents of permanent supportive housing have lease agreements in accordance with standard tenant/landlord laws and are not required to participate in services in order to maintain their tenancy.[1] Rents are subsidized to a level that is affordable to the resident, typically requiring state or federal affordable housing resources. PSH providers offer a variety of supportive services to their residents, ranging from referrals to other service providers to case management to intensive mental health or substance use clinical services. Some PSH providers are primarily property managers with some linkage to services added in, while others are embedded in medical systems.

Housing is a key social determinant of health—that is, an economic or social factor that influences a person's health and well-being and contributes strongly to health inequalities. People at risk of homelessness, or who are experiencing homelessness, often are in worse health than people who are stably housed. People experiencing homelessness and serious mental illness have life spans that are 20 to 25 years shorter on average than the general population, due in large part to preventable medical conditions.[2] An effective way to improve the health of unstably housed people is through permanent supportive housing.

A growing body of research from across the country documents the improved health outcomes attributed to supportive housing. In Illinois, formerly homeless individuals improved their health and reduced stress after moving into supportive housing.[3] In Denver, half of PSH residents experienced improved health status, while 43 percent improved mental health and 15 percent reduced substance use. In Seattle, chronic alcohol users in supportive housing reduced their alcohol use by 30 percent. Supportive housing residents in Chicago and San Francisco with HIV/AIDS experienced higher survival rates than a control group.[4]

Not only does PSH result in better health outcomes, it is also associated with cost savings, a great deal of which are achieved by reducing expensive healthcare costs and/or inappropriate institutionalization in hospitals, nursing homes, or other

1. Illinois Department of Human Services. FAQs – Permanent Supportive Housing. available here.
2. Parks, J., Svendsen, D., Singer, P., & Foti, M. (2006, October). Morbidity and Mortality in People with Serious Mental Illness, Technical Report. National Association of State Mental Health Directors, Medical Directors Council; available here.
3. Nogaski, A., Rynell, A., Terpstra, A., & Edwards, H. (2009, April). Supportive Housing in Illinois: A Wise Investment. Social IMPACT Research Center; available here.
4. Nardone, M., Cho, R., & Moses, K. (2012, June). Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case. Center for Health Care Strategies, Inc; available here.

segregated settings. In Illinois, PSH was associated with a 39 percent reduction in the total cost of services from pre- to post-supportive housing with an overall savings of $854,477. This was an average savings of $2,414 per resident annually.[5] These findings are borne out in communities across the country that have achieved similar cost reductions.[6]

Despite the return on investment supportive housing offers, its funding is threatened in Illinois. Illinois's legislature did not pass a state budget in FY 2016, resulting in suspended payments to many PSH providers; the legislature only passed an underfunded 6-month budget in FY 2017, which contains inadequate funding for supportive housing. Even before the budget impasse, recent proposed Illinois state budgets have significantly cut funding for supportive housing for people experiencing homelessness and people with mental illness. The FY 2016 proposed budget funding for supportive housing is 47 percent less than FY 2013 levels, 40 percent less than FY 2014 levels, and 46 percent less than FY 2015 levels.[7]

"Many supportive housing providers have been supported by grant funding for years. The days of re-lying on grant funding may be coming to a close, as demonstrated by Illinois' recent state budget experience," Kelly Cunningham, Deputy Administrator, Division of Medical Programs—HFS

Permanent supportive housing providers are looking to diversify their funding sources as the current funding model for supportive services is in flux. State governments generally have an interest in shifting the funding for supportive services as much as possible from state grant funding to sources like Medicaid, which splits the costs between the state and federal government. And while the U.S. Department of Housing and Urban Development (HUD) provides some funding for services, as well as the bulk of the money for housing, the federal government is encouraging communities to look to fund services from other sources so that HUD can focus its limited resources on housing.[8]

Medicaid funding is one option for supporting services that improve health outcomes for PSH residents and new opportunities are arising that would make it easier for PSH providers to access Medicaid. Increasing access to Medicaid for supportive housing providers would not only help PSH providers keep their doors open, but would improve the health of some of the hardest-to-serve and most vulnerable healthcare consumers.

This study documents barriers to accessing Medicaid for PSH providers, describes organizational capacities necessary to become a Medicaid biller, provides lessons learned from PSH providers that have gone through the process of becoming certified to bill Medicaid, and makes recommendations for changes to policy and practice that would expand access to Medicaid for PSH providers in Illinois.

5. Nogaski, A., *et. al., op. cit.*
6. Corporation for Supportive Housing. (2014, July). *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health*; available here.
See also: Supportive Housing Network of NY. *Cost Savings;* available here.
7. Author's analysis of data from Supportive Housing Providers' Association; available here.
8. United States Interagency Council on Homelessness. *Services in the CoC Program: A Guide to Assessing Value and Finding Funding Alternatives;* available here.

HOW MEDICAID IS DELIVERED IN ILLINOIS

While Medicaid is a federal health insurance program for low-income people and people with disabilities, the rules that govern how it is actually administered are largely determined by state Medicaid agencies and state legislatures. In Illinois, the Department of Healthcare and Family Services (HFS) is the state Medicaid agency.

HFS shares responsibilities for administering Medicaid with other agencies within the state government. Two agencies that typically interact with PSH providers that bill Medicaid are the Division of Mental Health (DMH) and the Division of Alcoholism and Substance Abuse (DASA), both housed within the Illinois Department of Human Services (IDHS). DMH is responsible for certifying that Medicaid providers are complying with the requirements to carry out mental health services under Rule 132 of Illinois's Medicaid regulations, and DASA is responsible for licensing providers of alcohol and substance abuse services under Rule 2060 and certifying that they are meeting the requirement to bill Medicaid for those services under Rule 2090. Among other things, Rule 132, Rule 2060, and Rule 2090 delineate the requirements a provider must meet (such as types of clinical professionals needed on staff, building/facility requirements, and staff training requirements), the policies and procedures the provider must have in place (such as patient confidentiality, quality assurance, and documentation/record-keeping), and the types of services that are allowable under those rules. Most Medicaid-billing PSH providers are certified to provide Medicaid-billable services through DMH, DASA, or both. In addition to becoming certified or licensed through DMH and/or DASA, Medicaid-billing PSH providers must enroll with HFS to bill Medicaid for service through their online provider enrollment system, IMPACT (launched in July 2015). Historically, there has been limited coordination between HFS, DASA, and DMH in drafting changes to Rules 132, 2060, and 2090, but agency representatives say that they are collaborating more than they have in the past.

CHANGES IN THE POLICY LANDSCAPE

New opportunities for PSH providers to use Medicaid to support their services arose with the passage of the Affordable Care Act (ACA) in 2010 and the expansion of Medicaid in 2013 and 2014. The Affordable Care Act allowed states to expand the populations eligible to receive Medicaid to include low-income adults; prior to the ACA, Medicaid was largely available to low-income children and their parents, low-income seniors, and people with disabilities. Illinois expanded Medicaid eligibility to include adults ages 19 through 64 with family incomes at or below 138 percent of the federal poverty level.[9] Most residents of permanent supportive

9. Illinois Department of Healthcare and Family Services. *Learn More About the Affordable Care Act and Implementation in Illinois;* available here.

SPOTLIGHT: IL MEDICAID PROVIDER ENROLLMENT

MENTAL HEALTH SERVICES

Rule: 59 Ill. Adm. Code 132 (a.k.a. Rule 132)

Governing agency: IDHS Division of Mental Health

Step 1: Pre-qualification for certification

- Submit required information, including licensure information from the Illinois Department of Financial and Professional Regulation, description of Rule 132 services they wish to offer, and national accreditation of mental health services, to DMH

Step 2: Certification

- After becoming pre-qualified, DMH's Bureau of Accreditation, Licensure and Certification will send the applicant the "Application for Certification of Medicaid Community Mental Health Services Programs"
- Submit application with accompanying attachments to DMH. The application will include descriptions of populations served; how clients will actively participate in treatment plans; and each service to be certified, how the applicant will provide it, and evidence demonstrating the applicant's ability to provide the services in compliance with Rule 132
- Certifications are valid for three years

ALCOHOL & SUBSTANCE ABUSE SERVICES

Rules: 77 Ill. Adm. Part 2060 (a.k.a. Rule 2060), 77 Ill. Adm. Part 2090 (a.k.a. Rule 2090)

Governing agency: IDHS Division of Alcoholism and Substance Abuse

Step 1: Obtain license through Part 2060 to provide alcoholism and other drug abuse treatment services

- Rule 2060 allows for licenses for treatment and intervention (DUI evaluation, DUI risk education, designated programs, and recovery homes)
- Applicants must submit application forms and attachments to DASA; attachments include a life safety report from an architect for all sites to be licensed, W9, and professional licensure information for medical directors/physicians

Step 2: Obtain Medicaid certification through Rule 2090

- DASA uses a combined application with steps for both licensure and certification.
- The applicant must have been licensed for at least two years and have at least two years of experience providing substance abuse services, among other requirements
- The application includes description of population served and need for services, schedule of services provided, description of outcome evaluation process, description of client outcomes for past two years, and documentation of accreditation
- Each site at which the applicant wants to provide services must be certified

Step 3: Enrollment with HFS

- Conducted online through the Illinois Medicaid Program Advanced Cloud Technology (IMPACT)
- In order to enroll or re-validate information in IMPACT, applicants must have a National Provider Identifier number, a current W9 on file with the State Comptroller, current professional certifications or licensure, and an application ID number (for currently-enrolled providers only)
- The organization must enroll through IMPACT first, and then each clinical provider who provides services to Medicaid clients through the organization will need to enroll through IMPACT and then associate with the organization.
- Providers must re-validate through IMPACT every 3 – 5 years.

housing have incomes that fall within that income range, and are therefore newly eligible for Medicaid. Now that so many more PSH residents are eligible for Medicaid, PSH providers that offer services that could be billable through Medicaid could be reimbursed for those services for a much larger proportion of their residents than they could before Medicaid expansion. This changes the calculus for some providers on whether taking on the administrative costs of Medicaid is worth the return on investment.

A 2011 Illinois law required most Medicaid beneficiaries to enroll in managed care programs, vastly expanding the presence of managed care organizations (MCOs) in Illinois's Medicaid system. MCOs are healthcare delivery systems designed to coordinate care and manage costs, service utilization, and quality of care. Medicaid beneficiaries are required to enroll in managed care programs if they live in particular metro areas,[10] and over 60 percent of Medicaid beneficiaries in Illinois have enrolled in managed care programs.[11] Before the advent of MCOs, medical providers billed the state directly for Medicaid reimbursements; now, for Medicaid beneficiaries who are members of MCOs, medical providers bill the MCOs for Medicaid reimbursements. HFS pays MCOs a set amount per member, per month (also known as "capitated payments"), and MCOs then negotiate payment mechanisms in contracts with medical providers. In Illinois, medical providers are typically paid on a fee-for-service model, where they bill the MCO for each unit of the service provided. Less frequently, some medical providers are also paid by MCOs through capitated payments, which reduce the administrative burden on the provider to some extent and allows for more flexibility in the provision of services. Some MCOs also incentivize medical providers to focus on health outcomes, rather than services provided, by offering performance-based payments for meeting health outcome goals.

The advent of managed care has posed some challenges for providers of Medicaid services. There are currently 13 managed care health plans in Illinois, and, since Medicaid providers must bill for services through MCOs when the patient is a MCO member, Medicaid providers must contract with every MCO of whom their patients are members. If the provider is certified to provide Medicaid through different rules—say, both Rule 132 and Rule 2090—they must negotiate a contract for each rule, for each MCO. This can be a large administrative burden, particularly for providers that do not have the administrative infrastructure to handle the contracting process. Billing MCOs can also be challenging; standards for what services will be covered and whether they need prior authorization vary from MCO to MCO, creating significant confusion for Medicaid providers.

A shift towards outcome-based health systems could potentially benefit PSH providers and other service providers that address the

10. Illinois Department of Healthcare and Family Services. (2016, July 1). *Care Coordination Map;* available here.
11. Illinois Department of Healthcare and Family Services. *Care Coordination;* available here.

social determinants of health that, historically, have not been the focus of the medical system. The way managed care is structured in Illinois, however, limits its benefits—continuing reliance on fee-for-service billing, inconsistent billing standards across MCOs, and cumbersome contracting processes pose barriers to accessing Medicaid for PSH providers that lack the administrative and billing capacity of traditional medical providers.

STATE-LEVEL INNOVATION ON MEDICAID AND PSH

It's clear that permanent supportive housing results in significant cost savings, giving Illinois all the more reason to find ways to support it—including expanding access to Medicaid. There are opportunities for state-level innovation to make Medicaid more accessible for PSH providers, and the federal Center for Medicaid Services (CMS) is actively encouraging states to do so.

One area that is ripe for innovation is expanding the set of services that are billable to Medicaid. A long-standing limitation on Illinois's PSH providers is that not all PSH providers offer services that are billable under Illinois's current Medicaid rules. Services that PSH providers typically offer that can be billable through Medicaid include clinical services, like mental health services or substance use services; care coordination; or, in the case of seriously mentally ill people, services that assist with activities of daily life.[12] However, many PSH providers offer non-billable supportive services that help residents (many of whom do not qualify as seriously mentally ill) obtain and maintain housing, which is a key determinant of health. Services that support tenancy for residents who do not meet the mental health criteria specified in Rule 132 (including specific diagnoses, levels of functioning, and deficits related to their diagnoses) are not currently billable through Medicaid under Illinois's current regulations.

CMS released guidance in June 2015 that clarified for state Medicaid offices that they could reimburse providers for "housing-related activities and services" that address social determinants of health—even though Medicaid cannot pay for direct housing costs themselves. Allowable services and activities include:

- individual housing transition services (such as developing housing support plans, assisting with housing search and application, and assistance with moving),
- individual housing and tenancy sustaining services (such as facilitating the landlord/tenant relationship, linkage with community resources, and assistance with the housing recertification process), and
- state-level housing related collaborative activities (such as developing and deepening working relationships between

12. Illinois Department of Human Services. *Rule 132 Diagnosis Codes – DMH;* available here.

state agencies and engaging in planning processes).[13]

CMS developed the Innovation Accelerator Program (IAP) to provide intensive technical assistance to states that want to create new innovative benefit packages such as those outlined in this guidance, and Illinois was selected to participate in the IAP.[14] The action taken as a result of the IAP process could significantly expand opportunities for PSH providers in Illinois to bill Medicaid for pre-tenancy and tenancy support services that they provide—representing an entirely new funding stream for many providers. Within the IAP process, Illinois is focusing on developing a benefit to support individuals coming out of nursing facilities and other institutions so that they can live in the community in the least restrictive setting possible, instead of pre-tenancy and tenancy support services for all Medicaid beneficiaries who need them.

Other states have started implementing innovative programs that integrate Medicaid and permanent supportive housing. Often, states accomplish this by applying for 1115, 1915(b), or 1915(c) waivers from CMS, which allow states to engage in innovative pilot or demonstration projects that advance the goals of Medicaid, use the savings that states get from managed care systems in innovative ways, or support long-term, non-traditional, or community-based care through a managed care system.[15]

In Massachusetts, the Community Support Program for Ending Chronic Homelessness (CSPECH) provides Medicaid reimbursement for community-based coordination for people living in PSH who had been chronically homeless.[16] CSPECH reduces Medicaid costs by serving a population of high users of services in their homes instead of on the streets or in shelter. A main component of their strategy is to provide intensive, in-person support to their high-risk clients through community support workers who help clients access primary care and social services, provide service coordination and linkage, accompany clients to appointments, stay in housing, and improve independent living skills. A key innovation with this model is that the Managed Care Entity (MCE) that spearheaded the project, the Massachusetts Behavioral Health Partnership (MBHP), has a contract for Medicaid reimbursement that rewards them financially for meeting performance goals related to improving the health outcomes of homeless adult men and women.[17] The flexible reimbursement structure for behavioral health service providers is also critical

13. Wachino, V. (2015, June 26). *CMCS Informational Bulletin: Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. Centers for Medicare and Medicaid Services, Center for Medicaid & CHIP Services; available here.
14. Medicaid.gov. *Promoting Community Integration Through Long-Term Services and Supports;* available here.
15. Medicaid.gov. *Section 1115 Demonstrations*; available here.
16. U.S. Department of Health and Human Services. (2015, February). *State Strategies for Improving Provider Collaboration and Care Coordination for Medicaid Beneficiaries with Behavioral Health Conditions;* available here.
17. CSPECH Elements profile

to CSPECH's success. The existing Community Support Program (CSP) rate requires providers to bill in 15-minute units of service (much like rule 132 billing in Illinois); however, under CSPECH, providers can be reimbursed through a day rate of $17 per person per day for any mix of the services allowable through CSPECH, and also for ranges of dates—for example, a provider can bill for a whole month even if the member did not receive services every day of that month.[18] This significantly streamlines the administration and billing processes. CSPECH estimates that the model results in annual medical cost savings of $10,000 per enrollee, for a total of $1,750,000 per year.[19]

CMS approved an 1115 waiver for New York that establishes a global Medicaid cap to cut costs and uses the savings generated for supportive housing services. This resulted in a $500 million investment in supportive housing, largely distributed through one-time capital expenses, pilot projects, and grant funds targeted to high cost homeless populations, as well as some ongoing service and operating contracts.[20] In 2016, New York State issued an RFP to support up to $25,000 per unit per year in services and operating funding for 1,200 units of supportive housing.[21]

In response to Hurricane Katrina, Louisiana used 1915(i), 1915(b), and 1915(c) Medicaid waivers to fund tenancy support services. These waivers allow Medicaid in Louisiana to support services that help individuals transitioning out of homelessness or out of institutions secure their own housing, as well as assistance that helps individuals maintain housing when it is at risk (Medicaid cannot pay for direct housing costs, however).[22] Louisiana's 1915(i) state plan amendment allows Medicaid beneficiaries to receive home- and community-based services, even if they are not at risk of institutionalization. Louisiana's behavioral health managed care organization, Magellan, manages supportive housing providers, keeps track of available units, and reimburses PSH providers for case management and housing-related services. The end result of this increase in funding for supportive housing is nearly 3,000 new units of supportive housing. [23]

California created an option for counties to fund tenancy supports for residents of supportive housing in a recently-approved 1115 Medicaid waiver. The savings generated by moving high-cost populations into housing will fund the transition and tenancy support services through California's "Whole Person Care" (WPC)

18. *Ibid.*
19. *Ibid.*
20. Corporation for Supportive Housing. (2015, June). *Summary of State Action: Medicaid and Housing Unit Creation*; available here.
21. New York State Office of Mental Health. *Empire State Supportive Housing Initiative Inter-Agency Service and Operating Funding Opportunity.* available here.
22. Wachino, V., *op. cit.*
23. Thiele, D., & Bailey, P. (2014, August). *Creating a Medicaid Supportive Housing Services Benefit: A Framework for Washington and Other States*. Corporation for Supportive Housing; available here.

strategy.[24] WPC targets frequent jail or hospital users and people at risk of or experiencing homelessness. WPC aims to improve health outcomes by identifying vulnerable users, sharing data between systems, instituting real-time care coordination, and evaluating health outcomes at the individual and population levels.[25] By requiring that managed care health plans participate in WPC pilots, and requiring that they contract with a variety of community-based organizations, WPC sets up the infrastructure to facilitate the coordination of care.

24. Centers for Medicare and Medicaid Services. (2015, December). *Special Terms and Conditions: California Medi-Cal 2020 Demonstration*; available here.
25. California Department of Health Care Services. *Medi-Cal 2020 Waiver – Whole Person Care (WPC) Pilots Frequently Asked Questions and Answers, Revision 4.0;* available here.

EMERGING PARTNERSHIP MODELS

"The ultimate goal of the Health Neighborhood to have HHO drive healthcare outside of its walls and into the lives of its participants, wherever they may be." – Ed Stellon, Executive Director, Heartland Health Outreach

A number of partnership models are emerging in Illinois that aim to increase access to Medicaid funding for permanent supportive housing providers through partnerships with Medicaid billers. The Health Neighborhood pilot, led by Heartland Health Outreach, will "lease" PSH provider care coordination and clinical staff members so that they can bill their services to Medicaid. The Better Health through Housing Pilot, led by the Center for Housing and Health, aims to coordinate with hospitals and managed care organizations to place high users of their services in supportive housing, stabilize them, and use the cost savings to fund the supportive housing providers.

HEALTH NEIGHBORHOODS

Heartland Health Outreach developed the idea to partner with PSH providers when it realized that they could help HHO achieve better health outcomes for their patients—an especially important goal in the era of the Affordable Care Act, which is moving medical care to a system that rewards outcomes rather than service volume. Unlike "standard" health clinics, which serve a mix of healthy and less-healthy patients, HHO serves a vulnerable population of people experiencing homelessness, who have a disproportionately high number of health challenges; in order for HHO to meet health outcome targets, they will need to employ creative strategies that address social determinants of health.

Permanent supportive housing residents, who often have complex medical needs, interact with their medical providers infrequently when compared to their relationships with case managers and other PSH staff. Lifestyle factors play a major role in health, and PSH staff have an opportunity to encourage their residents to make healthy lifestyle choices in a way that medical providers who see residents a couple times per year do not. The Health Neighborhood pilot's goal is to leverage PSH staff's relationships with their residents to improve residents' health.

HHO is certified to provide Medicaid-billable mental health, substance use, medical, and oral care services. The Health Neighborhood pilot will further expand access to those services for residents of permanent supportive housing through a staff leasing arrangement with four PSH providers: Chicago House, Deborah's Place, Heartland Human Care Services, and North Side Housing. HHO will work with PSH providers to identify their residents who chose HHO as their primary care provider and estimate the amount of staff time spent on supportive services that could be billed to Medicaid for those residents. HHO will then put the PSH providers' staff on HHO's payroll for the portion of their time they spend providing supportive services to HHO patients, paying a portion

of the staff member's salary. This will allow HHO to train the PSH providers' staff on the requirements for billing Medicaid, and then bill Medicaid for the services they provide.

The services that PSH provider staff offer, working under HHO's umbrella, could be clinical—like mental health or substance use counseling—or, if resident is seriously mental ill and has challenges with daily life that are related to their symptoms, the services could help them manage daily activities, like grocery shopping, managing hygiene, and food preparation. The staff members who offer these services could be licensed clinical providers or staff members with less education, depending on the nature of the service. At first, Health Neighborhood will start setting up staff leasing arrangements to provide clinical services through their Federally Qualified Health Center (FQHC) behavioral health encounter rate and, in later stages, lease staff time to provide services to seriously mentally ill residents through Rule 132 and care coordination services. The care coordination services provided by case managers could involve helping PSH residents manage their medication, make appointments and keep them, and alert medical providers when residents are facing health issues, as well as set and track population-level health outcome targets. A partnership model like Health Neighborhoods can bring Medicaid-billable services to PSH providers that do not have clinical providers on staff; under Rule 132, services do not have to be delivered by a licensed clinician as long as they are supervised by one, and a HHO clinician could play the supervisory role (substance use services under rules 2060 and 2090 do need to be delivered by a clinician, however), and care coordination services could be provided by anyone.

"Health Neighborhood starts to push HHO and its permanent supportive housing partners into population health management." – Ed Stellon, Executive Director, Heartland Health Outreach

Logistically, the staff leasing arrangement works well with this model because the PSH provider staff providing HHO services would be covered by HHO's malpractice insurance. It also allows HHO to share health information with PSH staff, if the PSH resident consents to it. HHO has experience implementing staff leasing arrangements, generally with physicians at hospitals who want to do work in the community. A huge area of focus for HHO will be ensuring that the leased staff are carrying out their services in conformance with Medicaid and HHO rules and documenting them appropriately; this will add additional training and quality management responsibilities on HHO staff, but they have not yet estimated how much extra staff time it will take.

Health Neighborhoods is still in a nascent stage of development. HHO has signed business associate agreements with the four PSH providers that allow HHO to share health information with the PSH providers so they can identify health needs and relevant Medicaid-billable services for their residents. HHO is in the process of hiring a staff member to coordinate Health Neighborhood relationships and logistics.

HHO notes that an important key to successful working

relationships in a partnership like this is to choose partners that have similar philosophies of care; as the PSH provider staff will essentially be providing HHO services, HHO must ensure that the services that residents receive are up to HHO's standards. It could be confusing to the resident if they receive conflicting healthcare messages from HHO and the PSH provider staff. As the pilot expands, HHO may consider working with providers who have differing philosophies of care and will invest in training the staff they lease on HHO's care strategies so that they are consistent.

"If we're not able to leverage the financial benefits afforded by ACA, we won't exist. We're so grant funded, and as that goes away, we've got nothing. The revenue stream that will support [our organization] will be Medicaid," PSH provider in Health Neighborhood partnership. "For the clients, [they] will have more streamlined, accessible medical care that meets medical and social determinant needs—those two systems would start talking to each other to make sure that they're both serving the patients as best as possible."

HHO expects that Health Neighborhood will benefit PSH residents by making it easier for them to receive services in their home or community, rather than at a clinic, and ultimately improve their health and well-being. HHO stands to benefit from Health Neighborhood by achieving better health outcomes for their patients (and receiving financial incentives for doing so) and potentially acquiring new patients if other PSH residents choose HHO as their primary care providers in order to reap the benefits of the Health Neighborhood. PSH providers benefit by having healthier residents, having staff who receive ongoing professional development to counsel their residents on health issues, and diversifying their funding to support the services they provide, all without needing to take on the administrative burdens of being a Medicaid biller.

"We want to demonstrate supportive housing's value to the healthcare system, and to learn and work together on the best way to coordinate services, reduce healthcare costs, and improve outcomes."
– Jessie Beebe, Health Services Specialist, Center for Housing and Health

BETTER HEALTH THROUGH HOUSING

The Better Health through Housing Partnership is a collaborative of 29 PSH providers that provide about 5,500 units of permanent supportive housing in the Chicago area, coordinated by the Center for Housing and Health (CHH), with the goal of seeking additional funding for supportive housing services from Medicaid providers, managed care organizations, and hospitals so that they can more effectively work together to coordinate services, reduce healthcare costs, and improve health outcomes. Participants in the collaborative decided it would be more effective to approach healthcare systems as a group rather than individually, so that they could achieve efficiencies in communication, negotiation, and contracting.

To date, Better Health through Housing has signed a contract with the University of Illinois at Chicago Hospital. UIC identifies high

users of its services; screens the patients through a panel of social workers and doctors to identify those who would be best suited for permanent supportive housing; and then Center for Housing and Health assigns these individuals to a permanent supportive housing provider that would best suit their needs and conducts intensive outreach to the individual, offering them temporary housing if need be until their permanent housing is ready. UIC pays CHH a per member, per month payment, and CHH distributes the majority of the payments to the housing providers. PSH providers offering housing through this collaborative have had to seek waivers from the Central Referral System, which is Chicago's intake and referral system for people seeking homeless services. The Central Referral System ranks people on a vulnerability index and prioritizes them on a list accordingly, with more vulnerable people getting a higher priority for housing. PSH providers that receive funding from the Chicago Continuum of Care need to fill vacant supportive housing units from the CRS. In order to place referrals from UIC, Chicago Continuum of Care-funded PSH providers need a waiver from CRS stipulating that they can fill units with people referred from UIC who may not be in CRS.

A key ingredient in this partnership is that UIC has good data on the housing status of its patients, as well as medical service usage. This allows them to narrow down their pool of patients to those who could benefit from supportive housing. Some health systems do not have the capacity to collect or analyze similar data. CHH noted that it can be challenging working with a hospital, especially on a project that is unlike anything they've tried before; working out contracts and the referral process took time. Additionally, the population they are targeting has significant challenges and it can take a long time to build trust, engage them, and get them to accept housing; having skilled outreach workers and supportive housing case managers facilitates this process. CHH hopes to expand the pilot to more hospitals, as well as to managed care organizations. Their initial proposals to MCOs were met with interest, though they are unsure how they could pay for it, since the case management and outreach services are not billable under Illinois's current Medicaid rules. There is also the question of what would happen to the funding for an individual's housing if they decide to switch their managed care provider or if they lose their Medicaid eligibility. CHH notes that it's best to work with PSH providers with similar philosophies of care so that they can speak with a unified voice to medical systems about the types of services they will provide. It is also important for PSH providers to collect and analyze data to demonstrate to health systems that the PSH services are improving health outcomes for their members/ patients.

"If you're a [permanent supportive] housing agency who wants to work with the Medicaid system, you need to have data to back up what you do and demonstrate outcomes that focus on improving the individual person's health." – Jessie Beebe, Health Services Specialist, Center for Housing and Health

METHODOLOGY

This study was designed to answer the following research questions:

1. What organizational capacities and supports are necessary for PSH providers to enroll as a Medicaid provider and contract with MCOs?
2. What opportunities and barriers exist to developing specialized contracts between Medicaid providers/MCOs and PSH providers?
3. What opportunities and barriers does the new HFS online provider enrollment system present for PSH providers seeking to bill Medicaid?
4. How have PSH providers that are currently enrolled as Medicaid providers navigated the contracting and credentialing process and what can be learned/shared from their experiences?

The following data sources informed the analysis of these questions:

- **Scan of policy landscape**—Researchers reviewed relevant research about innovative and promising policies that integrate PSH and Medicaid across the country.
- **Interviews**—Researchers conducted semi-structured interviews with 14 stakeholders, including representatives of MCOs and state agencies with authority over Medicaid in Illinois, Medicaid-billing PSH providers, non-Medicaid-billing PSH providers, and state and national policy experts. Interviews were conducted from April to May 2016.
- **Surveys of PSH providers**—A professional association of supportive housing providers (Supportive Housing Providers Association) provided a list of the 101 permanent supportive housing providers in Illinois. Of these, researchers were able to track down contact information for 95 of them, and 37 of the 95 PSH providers completed the full survey, while another three partially completed it. This resulted in a 39 percent response rate. Data were collected from March to April 2016.

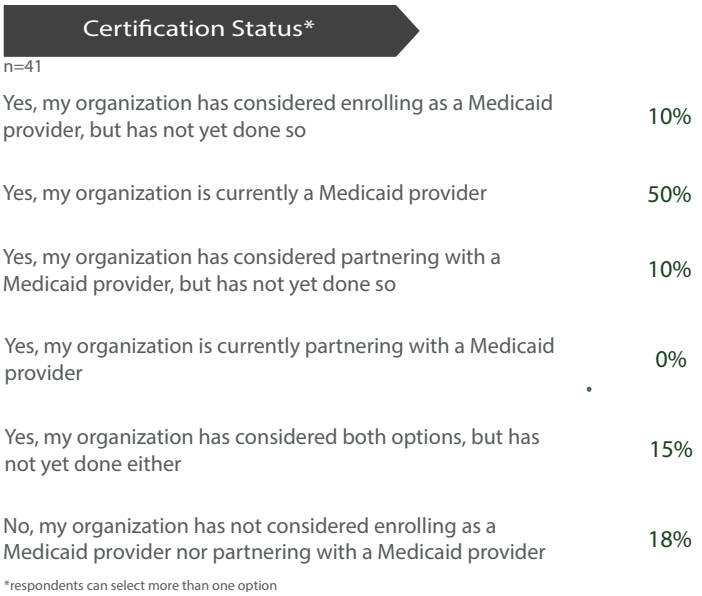
FINDINGS

SNAPSHOT OF PERMANENT SUPPORTIVE HOUSING PROVIDERS IN ILLINOIS

The characteristics and business models of permanent supportive housing providers can influence whether becoming a Medicaid biller or partnering with one is appropriate or beneficial for them. Half of the survey respondents were Medicaid-billing PSH providers, and half do not bill Medicaid (see fig. 1). The permanent supportive housing providers who responded to the survey were primarily on the smaller side. A little over half (54 percent) of PSH providers have less than 50 staff members, while 66 percent have budgets of $5,000,000 or less, and 51 percent have less than 100 units of housing. Models of supportive housing vary, with 54 percent of PSH providers offering single-site housing and 68 percent offering scattered site housing (35 percent of providers offer both single- and scattered-site housing). Survey respondents are spread throughout Illinois—43 percent of providers have units in the City of Chicago, while 40 percent have units in the rest of the Chicago metropolitan area and 40 percent have units in northern, central, and southern Illinois. Half (54 percent) of PSH providers serve a general population of people who are homeless or at risk of homelessness, while 65 percent serve specific populations with special needs. Of those who serve special-needs populations, the most common are people with mental illness (93 percent), alcohol users (67 percent), dually diagnosed (67 percent), drug users (59 percent), and people with chronic physical health

MEDICAID CERTIFICATION STATUS OF PSH PROVIDERS IN ILLINOIS

FIGURE 1



POPULATIONS SERVED BY MEDICAID BILLER STATUS

FIGURE 2

	Medicaid-billing PSH provider (n=18)	Non-Medicaid-billing PSH provider (n=9)
Have a mental illness	100%	78%
Homeless	72%	89%
Alcohol users	56%	89%
Dually diagnosed (specify)	67%	67%
Drug users	50%	78%
Have chronic physical health issues	50%	78%
LGBT	50%	56%
Victims of domestic violence	39%	67%
Formerly incarcerated	39%	67%
Have HIV/AIDS or related diseases	44%	44%
Veterans	33%	67%
Have developmental disabilities	44%	33%
Have physical disabilities	-	-
At risk of homelessness	11%	22%
Pregnant/parenting teens	11%	22%
Unaccompanied youth	6%	33%
Other	6%	22%

issues (59 percent) (see fig. 2). The majority of PSH providers (81 percent) have clinical professionals on staff (defined as physician, psychiatrist, psychologist, licensed clinical professional counselor, registered nurse, or licensed clinical social worker).

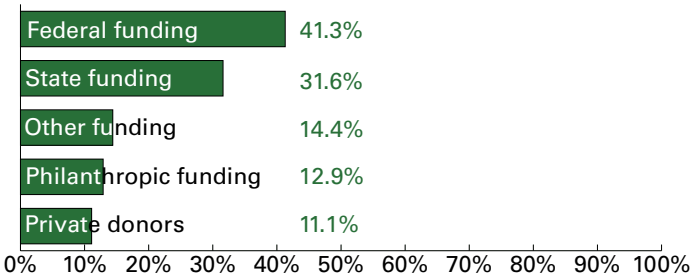
On average, 41 percent of PSH providers' budgets come from federal funding, 32 percent comes from state funding, 13 percent comes from philanthropic funding, 11 percent comes from private donors, and 14 percent comes from other sources (see fig. 3). PSH providers get paid for services through a variety of financing arrangements. All PSH providers receive grant funding, three-quarters receive fee-for-service payments, while 25 percent receive capitated or outcome-based payments (see fig. 4).

INTEREST IN MEDICAID AND BARRIERS TO ACCESS

Using Medicaid to pay for the supportive services they provide to their tenants is of great interest to permanent supportive housing

AVERAGE PERCENT OF BUDGET BY FUNDING SOURCE FOR PSH PROVIDERS IN ILLINOIS

FIGURE 3 (N = 31)



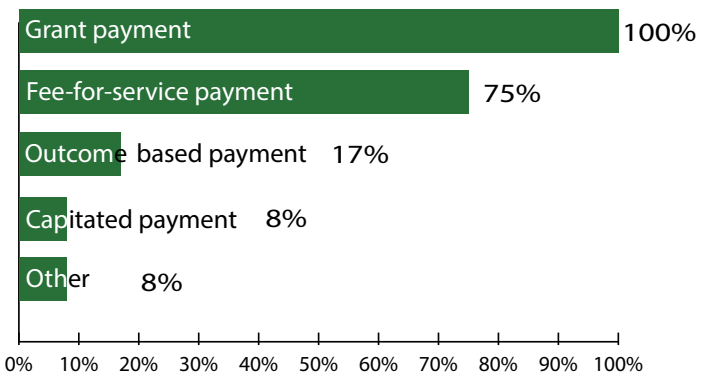
providers, particularly in the context of the instability around funding for supportive housing through Illinois's state budget. 85 percent of survey respondents are currently a Medicaid biller or have considered becoming a Medicaid biller/partnering with one. Two-thirds of the PSH providers that are not Medicaid billers nor partnered with one believe they will likely become Medicaid billers (47 percent) or partner with one (20 percent) in the future (see fig. 5). None of the respondents said that they were currently partnering with a Medicaid provider to provide Medicaid-billable services to their tenants (see fig. 1).

There are significant barriers in place to becoming a Medicaid biller, however. Of the 18 percent of PSH providers that have never considered becoming a Medicaid biller nor partnering with one, the top reasons are:

- "The administrative burdens of billing Medicaid are too high " (57 percent)
- "The requirements for becoming a Medicaid provider are unclear" (57 percent)
- "I am unsure of what changes I would have to make to my staff or organization in order to embark on a partnership" (57 percent), and

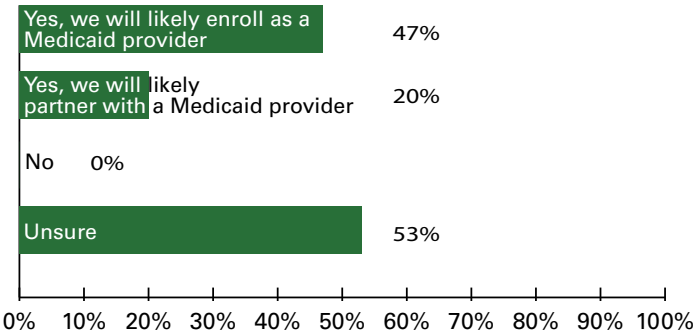
PAYMENT MECHANISMS FOR PSH PROVIDERS IN ILLINOIS

FIGURE 4 (N = 37)



INTEREST IN MEDICAID OF NON-MEDICAID-BILLING PSH PROVIDERS

FIGURE 5 (N = 15)



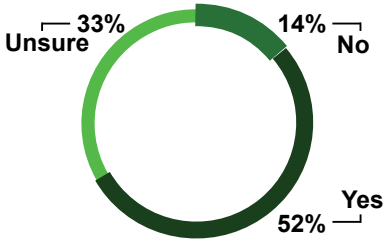
- "I am unsure whether a partnership would result in increased revenue for my organization" (57 percent)

Those who have considered becoming a Medicaid biller or partnering with one had similar concerns: top reasons for not pursuing these options include "the requirements for becoming a Medicaid provider are unclear" (40 percent) and "the administrative burdens of billing Medicaid are too high" (40 percent). The administrative requirements associated with being a Medicaid biller are barriers to accessing Medicaid: over half of all non-Medicaid billers said that the administrative requirements associated with billing for Medicaid services affect their decision about enrolling as a Medicaid biller (see fig. 6).

Non-Medicaid-billing PSH providers have not heard much encouraging information about being a Medicaid biller from their peers who do bill Medicaid. None of the non-Medicaid billers had heard that other PSH providers had positive experiences with being a Medicaid biller. Forty-three percent heard that other PSH providers had mixed experiences with Medicaid, while 43 percent had not heard about other PSH providers' experiences with

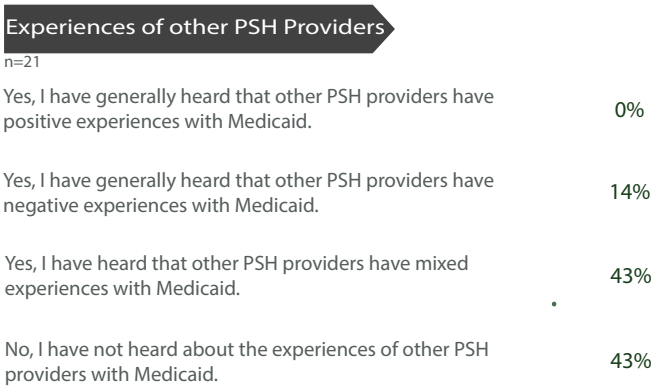
DO THE ADMINISTRATIVE REQUIREMENTS ASSOCIATED WITH BILLING FOR MEDICAID SERVICES AFFECT YOUR DECISION ABOUT ENROLLING AS A MEDICAID PROVIDER?

FIGURE 6 (N = 21)



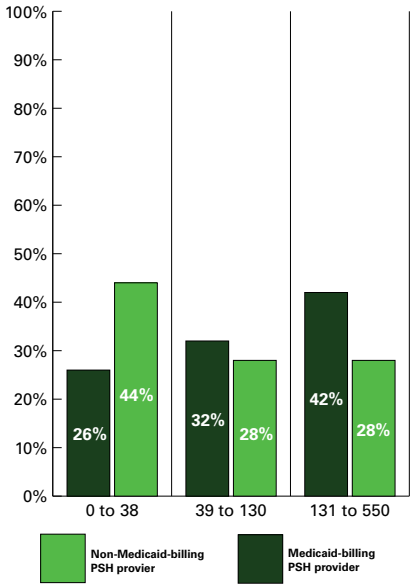
PERCEPTIONS OF OTHER PSH PROVIDERS' EXPERIENCES WITH MEDICAID, FROM NON-MEDICAID-BILLING PSH PROVIDERS

FIGURE 7



NUMBER OF UNITS BY MEDICAID BILLER STATUS

FIGURE 8 (N = 37)

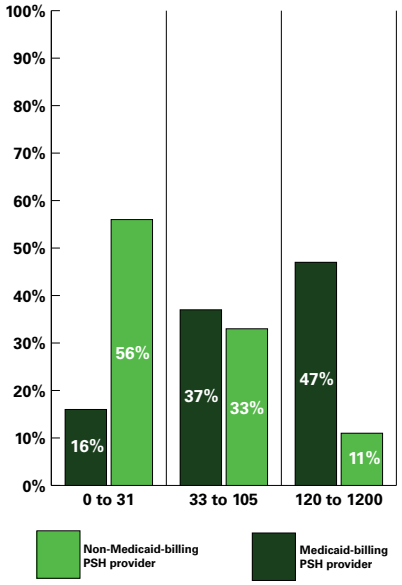


Medicaid at all (see fig. 7). Hearing about others' experiences with Medicaid did not seem to have a large impact on the likelihood of becoming a Medicaid biller or partnering with one; 60 percent of non-billers said that they are equally likely to become a Medicaid biller or partner with one after hearing about other PSH providers' experiences.

Despite significant interest in using Medicaid to fund supportive services, the convoluted process of becoming a Medicaid biller and the administrative burdens of administering Medicaid are discouraging PSH providers from pursuing this route. Simplifying the Medicaid certification and enrollment processes would make Medicaid more accessible to PSH providers.

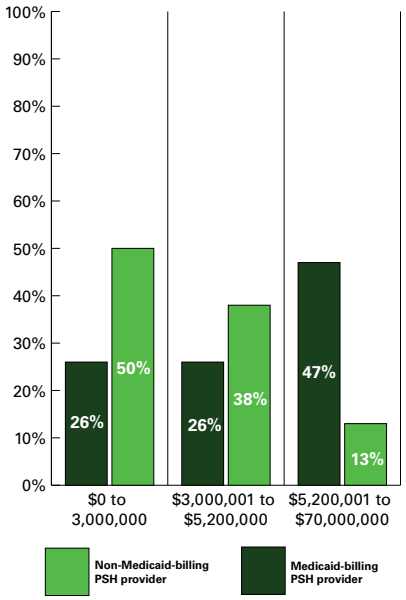
STAFF SIZE BY MEDICAID BILLER STATUS

FIGURE 10 (N = 37)



BUDGET SIZE BY MEDICAID BILLER STATUS

FIGURE 9 (N = 35)



ORGANIZATIONAL CAPACITIES/BARRIERS FOR ACCESSING MEDICAID

A number of organizational characteristics emerged from the surveys and interviews as capacities necessary to becoming a Medicaid biller or barriers to accessing Medicaid.

Size: Some providers that bill Medicaid believe that there is a size threshold at which it becomes worth it to take on the burdens of becoming a Medicaid biller, and the survey data show that Medicaid billers tend to be larger on average than non-Medicaid billers. Over 40 percent of Medicaid billers had over 130 units of permanent supportive housing, compared to just over a quarter of non-billers (see fig. 8). Medicaid billers tend to have larger budgets as well. 47 percent of Medicaid-billing PSH providers have budgets in the top third of all survey respondents' budgets (over $5.2 million), compared to just 13 percent of non-Medicaid-billing PSH providers (see fig. 9). Medicaid-billing PSH providers also have more staff; 47 percent have staff sizes in the top third of survey respondents' staff sizes (over 120 staff), compared to 11 percent of non-Medicaid-billing PSH providers (see fig. 10).

Clinical staff: Medicaid regulations require that organizations that bill Medicaid have clinical staff on hand to provide the billable services (or supervise the staff that provide services). This can be a barrier to accessing Medicaid for permanent supportive housing providers if they do not have clinical professionals on staff already, since their salaries are often higher than case managers or other

"There was lots of debate about whether or not we should [become Medicaid certified]. The big issue was infrastructure. It wasn't that the services that we provided were not compliant, because we knew they were—it was more that developing the billing infrastructure was going to be challenging. At the time, we were doing hard copy files—making that shift to electronic billing is a huge challenge." – Michael Banghart, Renaissance Social Services, Inc.

PRESENCE OF CLINICAL STAFF BY MEDICAID BILLER STATUS

FIGURE 11

	Medicaid-billing PSH provider (n=19)	Non-Medicaid-billing PSH provider (n=17)
Has clinical staff	100%	59%
Does not have clinical staff	0%	41%

staff typically at PSH providers. Just 59 percent of non-Medicaid-billing PSH providers have clinical professionals on staff, whereas 100 percent of Medicaid providers do (see fig. 11). In a similar vein, Medicaid-billing PSH providers advised that it does not make a lot of sense to incur the costs of being a Medicaid biller under Illinois's current Medicaid rules if your organization does not provide clinical services and has no plans to start providing them in-house. Under the current Medicaid rules, it may make more sense for a PSH provider to partner with a Medicaid biller to provide services to their residents.

Electronic medical records and billing capacity: PSH providers that become Medicaid billers often must overcome both technological and staff capacity hurdles when it comes to adopting electronic medical records and billing Medicaid appropriately. Meeting Medicaid's billing requirements is "near impossible" to do without an electronic billing system and electronic health/client records in place, says one Medicaid biller. Some PSH providers operate primarily on grants and do not bill any insurance for services, so in order to become Medicaid billers, they must select and purchase the software(s), develop procedures and policies, and train their staff to comply with them. One Medicaid-billing PSH provider who recently navigated the process found that there were few resources in place to help him select affordable software that met his organization's needs—often, billing and medical records software is targeted at a medical clinic, and software designed for mental health case management would better suit his organization's needs—and the challenges of training his staff were substantial. Non-Medicaid-billing PSH providers are much less likely to have an electronic billing system (61 percent lack a billing system) than Medicaid-billing PSH providers (7 percent lack a billing system) (see fig. 12). Non-Medicaid-billing PSH providers list the staff and technological hurdles posed by billing Medicaid as top concerns they have about the administrative impact that Medicaid would have on their organization (see fig. 13).

Administrative staff: In addition to the technology and training costs of enacting new administrative procedures, many PSH providers that become Medicaid billers need to hire new administrative and compliance staff with experience in billing Medicaid. In fact, PSH providers hired more administrative staff than any other type of position when they became Medicaid billers. Medicaid billers hired an average of 2.2 administrative

BARRIERS TO ADMINISTERING MEDICAID, BY MEDICAID BILLER STATUS
FIGURE 12

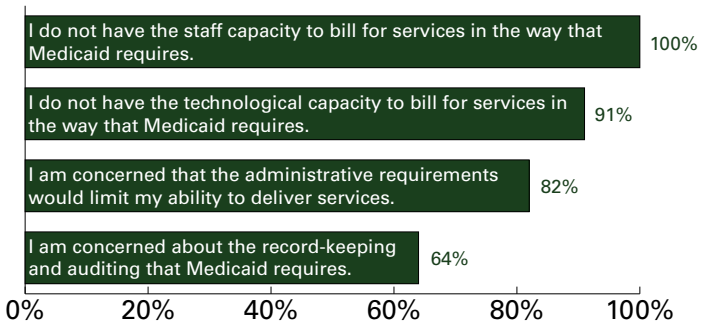
	Medicaid-billing PSH provider (n=14)	Non-Medicaid-billing PSH provider (n=18)
My organization does not have internet access	0%	0%
Not all staff members within my organization have email capability	0%	0%
My organization does not currently use an electronic billing system	7%	61%
My organization does not currently have the capacity to measure the success of services we provide	0%	6%
My organization does not document services in an electronic resident/client record	21%	17%
None of the above	64%	17%
Other	14%	22%

staff, 1.3 clinical staff, 0.2 case management staff, 0 outreach staff, and 0.5 other staff in order to become a Medicaid biller (see fig. 14).

Varied funding: Many interviewees emphasized how crucial it is for PSH providers to have varied funding streams, even as they explore the possibility of adding Medicaid to the mix. Medicaid will not reimburse the costs of housing, so PSH providers will always need alternate funding sources to cover those substantial costs.

Quality assurance procedures: Becoming a Medicaid provider often involves adopting new quality assurance procedures for PSH providers. For example, there are strict rules in place for client record-keeping—what information is collected, how it is maintained, and how long it should be kept. Rule 2060, governing the provision of alcohol and substance abuse services, requires

CONCERNS ABOUT MEDICAID'S ADMIN. IMPACT, FROM NON-MEDICAID-BILLING PSH PROVIDERS
FIGURE 13 (N = 11)



AVERAGE NUMBER OF NEW STAFF HIRED TO ENROLL AS MEDICAID PROVIDER

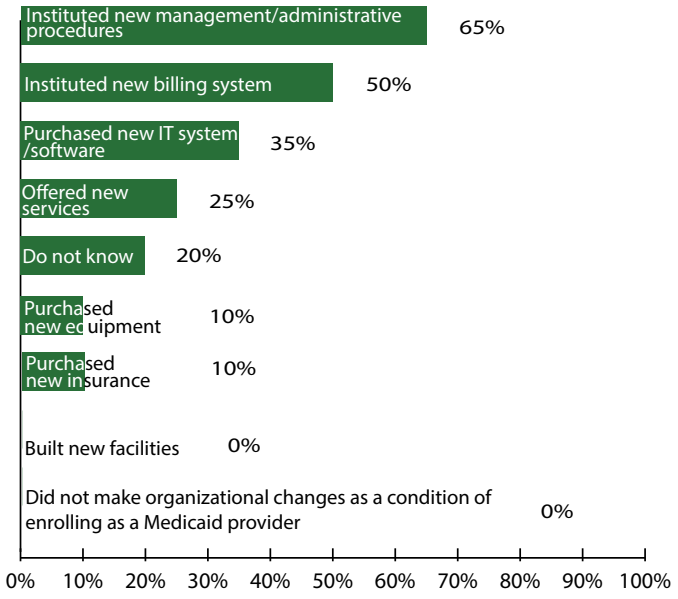
FIGURE 14

New Staff	Average
Administrative (n=6)	2.17
Clinical (n=6)	1.33
Case management (n=5)	0.20
Other (n=4)	0.50
Outreach (n=4)	0.00

that client records be kept for five to six years and contain documentation on treatment assessment, diagnosis, treatment plan, patient education, all treatment-related correspondence, and more.[26] Many PSH providers may not keep client records that meet Medicaid's standards, or may not have systems in place for maintaining them for five or six years; and the documentation procedures could be well outside the norm for some providers. Changing policies and procedures for billing and quality assurance requires extensive staff training. The most common organizational changes Medicaid-billing PSH providers made in order to become Medicaid billers were instituting new management/administrative procedures (65 percent), instituting new billing systems (50 percent), and purchasing new IT systems/software (35 percent) (see fig. 15).

ORGANIZATIONAL CHANGES MADE BY PSH PROVIDERS TO ENROLL IN MEDICAID

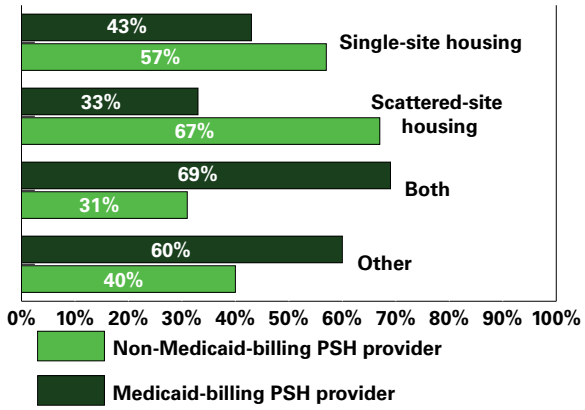
FIGURE 15 (N = 17)



Housing model: The structure of a PSH provider's housing—whether it is in a single site or scattered site—could affect how easy it is to deliver Medicaid billable services to their residents. Just a third of PSH providers that only have scattered-site housing are Medicaid billers, compared to 43 percent of single-site providers and 70 percent of providers that have both. One reason for this may be that it is harder to deliver Medicaid billable services to people living in scattered-site units. Medicaid does not currently allow organizations to bill for travel time, so it is financially challenging to have staff travel from location to location to deliver services. While organizations licensed to deliver mental health services under Rule 132 have some flexibility to deliver community-based services, organizations licensed to

26. 77 Ill. Adm. Part 2060.325. Patient/Client Records; available here.

HOUSING MODEL BY MEDICAID BILLER STATUS
FIGURE 16



provide substance abuse services under Rule 2060 must provide their Medicaid-billable services in a licensed facility (with some exceptions).[27] It may be difficult to get tenants living in scattered site housing to the licensed facility to receive services. In addition, not all PSH sites would meet the physical requirements necessary for a DASA license—providers must submit a physical building plan and have certain safety measures in place—and if a provider has multiple sites, they must obtain separate licenses for each site.

OTHER BARRIERS

In addition to the need to develop new organizational capacities to administer Medicaid, other contextual barriers make it challenging for PSH providers to access Medicaid.

Medicaid reimbursement rates: Many providers noted that the Medicaid reimbursement rates, particularly for psychiatry services, do not always cover the full costs of providing the services. Therefore, providers need to subsidize the provision of some services with other funding sources. Medicaid reimbursement rates are set by HFS and, given recent budget instability, rates have been cut in recent years.[28]

The need to obtain two certifications to provide mental health and substance use services: Many people at risk of homelessness grapple with both mental health and substance use disorders. Yet, to provide the full cohort of services addressing these commonly co-occurring issues, providers need to be certified separately to bill Medicaid through both DASA and DMH. This requires completing two complex, multi-step certification and enrollment processes, and then going through the administration and billing of services administered by two separate departments.

27. 77 Ill. Adm. Part 2060.201. Types of Licenses; available here.
See also 77 Ill. Adm. Part 2060.203. Off-Site Delivery of Services; available here.
28. Illinois Department of Healthcare and Family Services. (2015, May 1). *Reimbursement Rate Reductions Effective May 1, 2015 through June 30, 2015;* available here.

Lack of information about completing the Medicaid certification and enrollment processes: As noted above, many providers are unclear about what organizational capacities are required to become a Medicaid biller and how to get started and complete the process of enrolling as a Medicaid billers. Some interviewees expressed a desire for a "step-by-step" guide or "guidance for every step of the way" for the process of becoming a Medicaid biller—a project that would require the collaboration of the many state agencies with jurisdiction over Medicaid. Several providers that recently completed the process of becoming a Medicaid biller noted that it would have been helpful to have a consultant or other outside assistance to complete the process, since it was difficult to coordinate on top of regular executive director duties.

Limitations in billable services: Several Medicaid-billing PSH providers concluded that, under Illinois's current Medicaid rules, it only makes sense to take on the costs of billing Medicaid if your organization directly provides clinical services (or wants to move in that direction), such as mental health services and substance use services, or serves a severely mentally ill population. While many supportive housing residents need behavioral health services, not every supportive housing provider offers those services through their own organization; they may, instead, link their residents to services at another organization. In order for PSH providers with a linkage-to-services model to maximally benefit from Medicaid funds, Illinois would need to update its Medicaid rules to allow providers to bill for pre-tenancy or tenancy support services that PSH case managers often provide. For providers who wish to become licensed to provide substance use services through DASA, they would not be able to just offer those services to residents of their supportive housing—they must be open to serving other people who qualify for substance use services.[29]

Contracting with and obtaining prior authorization for services from Managed Care Organizations: After enrolling as a Medicaid provider, Medicaid billers must contract with MCOs of whom their residents are members in order to create a viable Medicaid program, since Medicaid billing is handled through MCOs for their members. This means that Medicaid providers must negotiate contracts with potentially dozens of MCOs (depending on how many are active in their service area), each of whom has their own billing, payment, and administrative procedures, as well as standards for what services are billable to Medicaid. For example, with Rule 132 mental health services, it's not always clear whether a resident's mental health diagnosis, level of functioning, and skills deficits will result in approval for billing Medicaid until you submit the bill for the service.

Managed Care Organizations (MCOs) require that Medicaid providers obtain prior authorization for some services in order to get reimbursed for those services. The process of obtaining

29. Interview with Rick Nance and Jayne Antonacci, IL Department of Human Services Department of Alcohol and Substance Abuse. April 20, 2016.

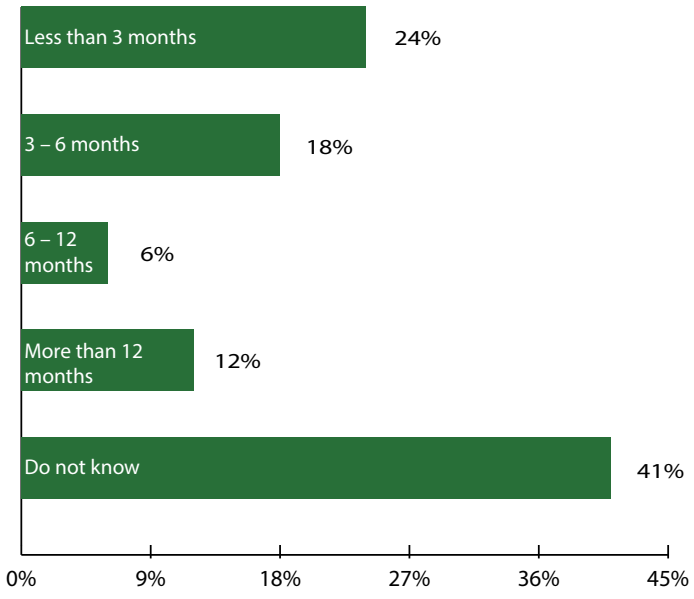
prior authorization is designed to cut down on the provision of unnecessary medical services, but some PSH providers found that they had trouble obtaining prior authorization for some behavioral health services that were medically necessary, connected to patients' treatment plans, and explicitly permitted under Illinois's Medicaid rules. They also found that the standards for prior authorization varied from one MCO to another, making it challenging to provide consistent services to a population of members of different MCOs. A provider noted that varying standards for prior authorizations across different MCOs pose challenges, saying, "we are frustrated by the multiple payer system that now exists and the lack of continuity across MCOs regarding such issues as prior [authorizations] for services." One provider, alongside several other Medicaid billers, worked with MCOs in their area to expand their understanding of the requirements for Rule 132 services needed by their residents and reported a greater success rate at obtaining prior authorizations. Representatives from DASA noted that they're in frequent communication with MCOs to clarify rules and policies.

LESSONS LEARNED: THE PROCESS OF BECOMING A MEDICAID BILLER

Navigating the process of becoming a Medicaid biller can pose many hurdles for PSH providers. Providers must learn the state's Medicaid requirements for whatever certifications they wish to obtain and check to see whether their organization meets the state's criteria—do they have the right clinical and administrative

LENGTH OF MEDICAID PROVIDER ENROLLMENT PROCESS FOR PSH PROVIDERS IN ILLINOIS

FIGURE 17 (N = 17)



staff on board? Do they provide services that could be billable? Do they have the right administrative procedures and infrastructure in place to comply with Medicaid requirements? Providers must decide what rule under which they want to become certified to provide Medicaid billable services. After making the requisite organizational changes (such as instituting new procedures or hiring new staff) and following the steps[30] to become licensed and/or certified through DASA or DMH, providers must then enroll to become a Medicaid biller through the state's online Medicaid provider enrollment system, IMPACT.

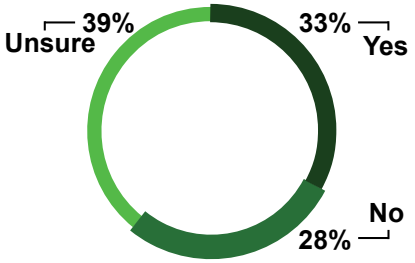
The time it took for providers to become a Medicaid biller was not typically too long. Of the respondents who knew how long it took for their organization to become a Medicaid biller, 70 percent took less than six months (see Figure 17).

Several providers noted that it would have been useful to receive more intensive training or assistance with the Medicaid provider enrollment process. Only a third of Medicaid-billing PSH providers received training or assistance with the Medicaid enrollment process (see fig. 18). When providers did receive training, they generally benefitted from it: 83 percent of those who received training found it somewhat or very helpful (see fig. 19). While the quality of assistance currently available to PSH providers is high, it needs to expand its footprint.

To the extent that Medicaid-billing PSH providers had to incur costs in order to meet Medicaid requirements, it was unclear whether those costs were sustained over time. Over a third of Medicaid providers found that personnel costs associated with becoming a Medicaid biller were sustainable over time, while

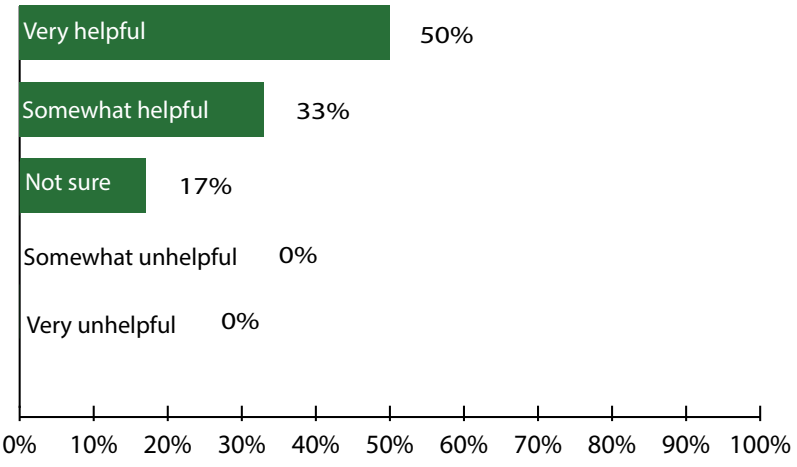
PERCENT OF MEDICAID-BILLING PSH PROVIDERS THAT WERE TRAINED ON ENROLLMENT PROCESS

FIGURE 18 (N = 18)



HELPFULNESS OF TRAINING ON MEDICAID PROVIDER ENROLLMENT PROCESS

FIGURE 19 (N = 6)



30. Illinois Department of Human Services. *Become an Alcoholism & Substance Treatment & Intervention Provider*; available here.
See also Illinois Department of Human Services. *Becoming a Medicaid Certified Community Mental Health Provider*; available here.

over half were not sure (see fig. 20). Nearly half (47 percent) of Medicaid providers found that the administrative costs associated with becoming a Medicaid biller were sustainable over time, while 18 percent were not sure (see fig. 21). Since some Medicaid-billing PSH providers have been billing Medicaid for decades, current staff may not know what costs were incurred when they originally enrolled as Medicaid billers.

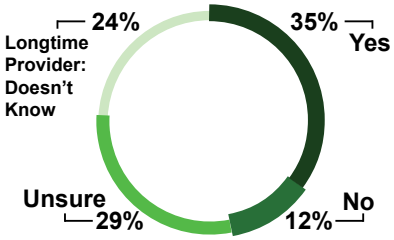
IMPACT

In July 2015, the Illinois Department of Healthcare and Family Services launched a new online system, IMPACT, that organizations are required to use to become enrolled as a Medicaid provider. Reports arose that many providers were encountering trouble when attempting to enroll as a Medicaid provider by the original deadline of December 31, 2015 (the deadline was later extended to June 30, 2016).[31] Of survey respondents, most Medicaid-billing PSH providers said they were able to enroll with IMPACT by the original deadline (63 percent) (see fig. 22). For those who could not, common barriers include technological errors and errors in Medicaid IDs and certification numbers. These estimates of the rate of difficulty using IMPACT may be conservative, however. Survey respondents were often from organization leadership, while administrative, billing, or compliance staff are likely to be IMPACT users in their organizations. Respondents may not know for sure whether their organization was able to enroll in IMPACT on time.

Smaller organizations were more likely to be able to enroll on time with IMPACT than large organizations. 80 percent of organizations with budgets below $3 million and less than 38 units[32] were able to enroll on time, compared to 56 percent of organizations with budgets above $5.2 million and 63 percent of organizations with more than 130 units[33] (see fig. 23 and 24). This may indicate the

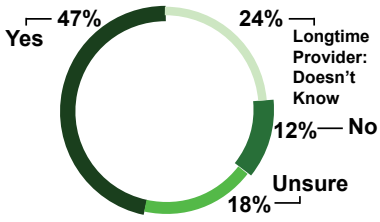
IF YOU HIRED NEW STAFF IN ORDER TO BECOME A MEDICAID PROVIDER, HAVE THE PERSONNEL COSTS BEEN SUSTAINABLE OVER TIME?

FIGURE 20 (N = 17)



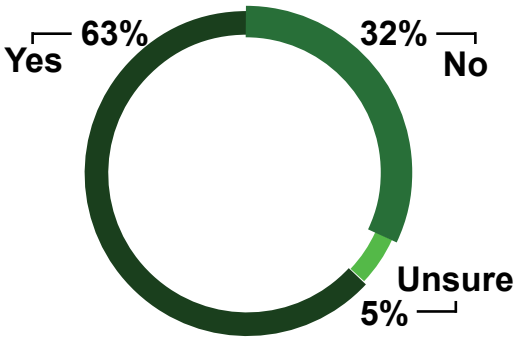
IF YOU MADE ADMINISTRATIVE CHANGES IN ORDER TO BECOME A MEDICAID PROVIDER, HAVE THE COSTS BEEN SUSTAINABLE OVER TIME?

FIGURE 21 (N = 17)



PERCENT OF MEDICAID-BILLING PSH PROVIDERS THAT ENROLLED IN IMPACT ON TIME

FIGURE 22 (N = 19)



31. Illinois Department of Healthcare and Family Services. *IMPACT Home;* available here.
32. These cutoffs indicate the bottom third of the distributions of budget sizes and numbers of units among survey respondents.
33. These cutoffs represent the top third of the distributions of budget sizes and numbers of units among survey respondents.

ON-TIME IMPACT ENROLLMENT BY PSH PROVIDER BUDGET SIZE

FIGURE 23 (N = 19)

	$0 to $3,000,000	$3,000,001 to $5,200,000	$5,200,001 to $70,000,000
Enrolled in IMPACT on time	80%	60%	56%
Did not enroll in IMPACT on time	20%	40%	33%
Not sure	0%	0%	11%

difficulty of having to enroll multiple sites through IMPACT.

Having smaller staff sizes posed challenges to enrolling in IMPACT. A third of organizations with fewer than 31 staff were able to enroll on time, compared to 86 percent of organizations with 32 – 105 staff and 56 percent of organization with more than 120 staff[34] (see fig. 25). Organizations with fewer staff may not have the administrative capacity to effectively navigate IMPACT; the relatively low enrollment rates for the largest organizations may be related to the challenges of enrolling multiple sites and providers through IMPACT.

When Medicaid-billing PSH providers received training or assistance with IMPACT, they generally found it to be helpful. Sixty-one percent of Medicaid billers received training or assistance with the IMPACT system, and 73 percent found it to be somewhat or very helpful (see fig. 26 and 27). Providers most commonly received training or assistance via webinar or conference call (91 percent) or online materials (36 percent), and all providers who received training or assistance got it from state agencies.

IMPACTS OF BEING A MEDICAID BILLER

Medicaid-billing PSH providers reported that Medicaid has a range of impacts on their organizations—some positive, some negative.

ON-TIME IMPACT ENROLLMENT BY PSH PROVIDER NUMBER OF UNITS

FIGURE 24 (N = 19)

	0 to 38	39 to 130	131 to 550
Enrolled in IMPACT on time	80%	50%	63%
Did not enroll in IMPACT on time	20%	33%	38%
Not sure	0%	17%	0%

Medicaid is a reasonably stable source of funding for some types of supportive services in a funding environment full of instability, but the administrative requirements create new burdens for staff

34. These cutoffs indicate the borders of the bottom, middle, and highest terciles in the distribution of staff sizes among survey respondents.

ON-TIME IMPACT ENROLLMENT BY PSH PROVIDER STAFF SIZE

FIGURE 25 (N = 19)

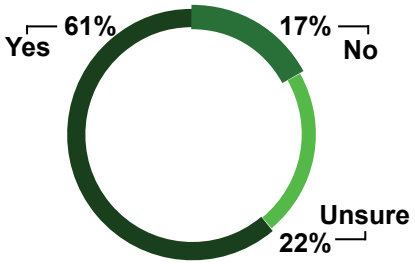
	0 to 31	33 to 105	120 to 1200
Enrolled in IMPACT on time	33%	86%	56%
Did not enroll in IMPACT on time	67%	14%	33%
Not sure	0%	0%	11%

and may even change the organization's philosophy of care.

Medicaid-billing PSH providers appreciate that Medicaid helps them diversify their funding streams. One provider notes, "we have no choice [but to bill Medicaid] if we want to survive in this new funding environment." Half of Medicaid-billing PSH providers find that they get a very good or somewhat good return on investment from being a Medicaid biller, while 39 percent receive a very poor or somewhat poor return on investment (see fig. 28). Medicaid-billing PSH providers seemed to weather Illinois's budget crisis better than non-Medicaid-billing PSH providers. Nearly all of non-Medicaid-billing PSH providers (94 percent) cut staff in response to the budget crisis, compared to 63 percent of Medicaid billers. Half of non-Medicaid billers reduced caseloads, compared to 21 percent of Medicaid billers. Nearly three-quarters of non-Medicaid-billing PSH providers had to tap cash reserves, as did 63 percent of Medicaid-billing PSH providers. One exception to the trend is that over half of Medicaid-billing PSH providers increased their wait lists due to the budget impasse, compared to just 22 percent of non-Medicaid-billing PSH providers (see fig. 29).

PERCENT OF MEDICAID-BILLING PSH PROVIDERS THAT RECEIVED TRAINING ON IMPACT

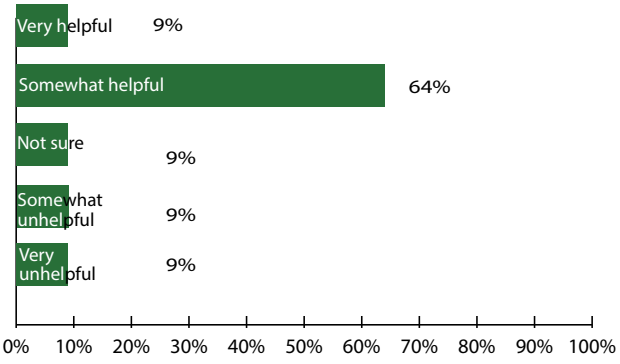
FIGURE 26 (N = 18)



Most Medicaid-billing PSH providers use Medicaid funds to shore up their existing operations, rather than expand into new areas. Just 18 percent of Medicaid-billing PSH providers expanded their geographic footprint as a result of becoming a Medicaid biller, while 12 percent are serving new client populations and 6 percent

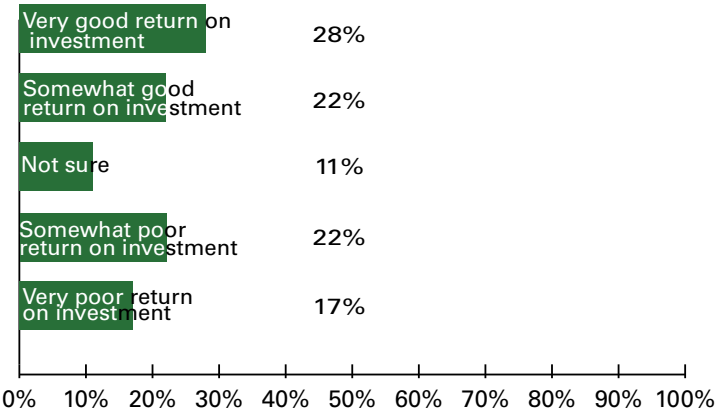
HELPFULNESS OF IMPACT TRAINING/ ASSISTANCE

FIGURE 27 (N = 11)



PERCEPTIONS OF MEDICAID RETURN ON INVESTMENT, MEDICAID-BILLING PSH PROVIDERS

FIGURE 28 (N = 18)



serve more clients in their existing target populations. 18 percent of the Medicaid billers that responded to the survey had been billing Medicaid for so long that the staff are unsure how the introduction of Medicaid impacted their operations, however, so these estimates may be conservative (see fig. 30).

The administrative burdens of billing Medicaid were substantial for many Medicaid-billing PSH providers. Slightly more than half (53 percent) of Medicaid-billing PSH providers found the administrative impact of being a Medicaid biller to be somewhat

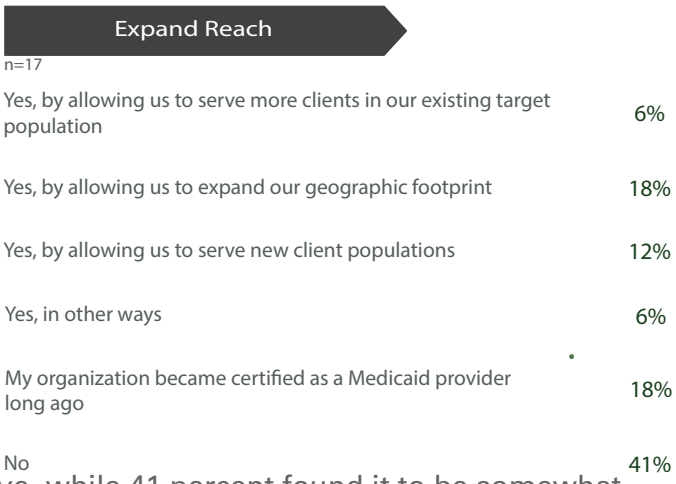
IMPACTS OF ILLINOIS BUDGET CRISIS ON PSH PROVIDERS, BY MEDICAID BILLER STATUS

FIGURE 29

	Medicaid-Billing PSH Provider (n=19)	Non-Medicaid-Billing PSH Provider (n=18)
Reduce staff	41%	59%
Reduce client caseload	31%	69%
Close locations/reduce number of units	50%	50%
Reduce services provided	46%	54%
Increase waiting list	71%	29%
Change services provided	58%	42%
Reduce staff salaries/benefits	40%	60%
Skip payroll	33%	67%
Tap into cash reserves	48%	52%
Tap into lines of credit	46%	55%
Other	0%	100%

HAS ENROLLING AS A MEDICAID PROVIDER ALLOWED YOU TO EXPAND YOUR ORGANIZATION'S REACH?

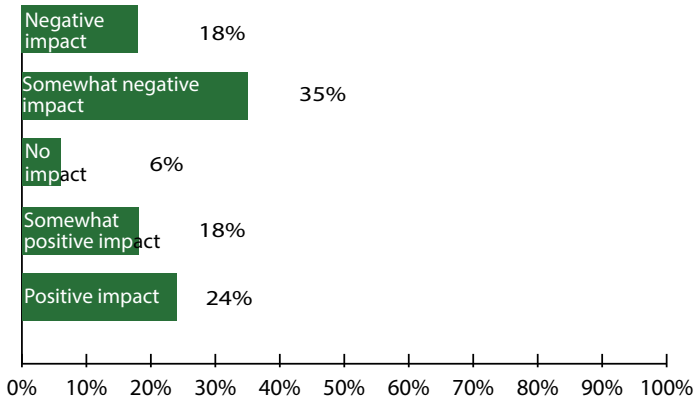
FIGURE 30



negative or negative, while 41 percent found it to be somewhat positive or positive (see fig. 31). Some interviewees noted that Medicaid requirements led them to change the services they provide in order to meet Medicaid requirements. For example, one PSH provider that provides many community-based services now instructs its staff to be mindful about planning their day in order to minimize travel time (which is not billable to Medicaid). The result of this is that the geographic scope of their services has narrowed. Another provider shifted their focus away from serving veterans, who generally do not qualify for Medicaid. Some providers had to change the composition of their staff's work, shifting duties so that staff who provide Medicaid services spend a certain percentage of their hours in front of residents. Introducing Medicaid into the mix can add many new tasks to staff members' plates, including conducting a Mental Health Assessment upon which the treatment plan must be based, helping residents enroll in Medicaid, and getting them re-enrolled every year. Medicaid requirements can

ADMINISTRATIVE IMPACT OF MEDICAID ON MEDICAID-BILLING PSH PROVIDERS

FIGURE 31 (N = 17)

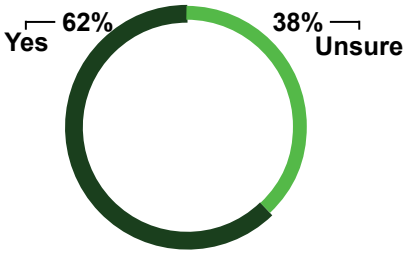


also change the organizational culture. Thresholds, a Chicago-area PSH provider that historically developed community-based mental health teams led by people with lived experience of homelessness, substance use, mental health issues, or other barriers, had to switch to having clinical professionals lead their teams so that they could bill Medicaid for those services.

Despite the challenges posed by the administrative requirements, most (62 percent) Medicaid-billing PSH providers recommend that other PSH providers become Medicaid billers (see fig. 32). They do caution that billing Medicaid would benefit some providers more than others, including organizations that serve adults with mental illness, organizations with the administrative capacity to comply with Medicaid requirements, and organizations that already provide services that could be billable to Medicaid. Providers say that Medicaid is "the way of the future" for PSH funding and a "critical funder to the population we serve." Of the 38 percent of providers who were unsure whether they would recommend that other providers bill Medicaid, they elaborated that it "depends on the specific return on investment for each organization," it only makes sense to bill Medicaid "if they are able to partner with an existing Medicaid provider for the administrative infrastructure," and organizations should "seriously consider the admin costs of third party billing, software, and quality assurance."

WOULD YOU RECOMMEND THAT OTHER PSH PROVIDERS ENROLL AS MEDICAID PROVIDERS?

FIGURE 32 (N = 13)



The services offered by Medicaid-billing PSH providers and non-Medicaid-billing PSH provider differ from each other (see fig. 33). A greater proportion of Medicaid-billing PSH providers provide clinical services (including mental health, substance use, and primary care) through their organization than do non-Medicaid billers. Non-Medicaid billers are more likely to offer some non-clinical services than are Medicaid billers. This could indicate that Medicaid billers focus their offerings on Medicaid-billable services, while non-billers offer a broader range of services. Medicaid-billing PSH providers are more likely to offer mental health services than non-billers (89 percent vs. 35 percent), as well as medication monitoring (78 percent vs. 24 percent), substance use services (61 percent vs. 47 percent), and primary care (33 percent vs. 12 percent). Similar percentages of billers and non-billers offer case management (94 percent of billers and non-billers), clothing (39 percent of billers and 47 percent of non-billers), educational/vocational training (39 percent of billers and 35 percent of non-billers), ESL classes (11 percent of billers and 12 percent of non-billers), transportation assistance (67 percent of billers and 71 percent of non-billers), and other health services (33 percent of billers and 29 percent of non-billers). Non-billers were more likely to offer legal services than billers (29 percent vs. 11 percent), as well as employment assistance (77 percent vs. 67 percent), HIV/AIDS related services (35 percent vs. 17 percent), and financial literacy (77 percent vs. 50 percent). These differences may be because providers with a pre-existing business model that includes providing clinical services gravitate towards billing Medicaid or perhaps because organizations shift their foucs to

become more clinical in order to capture Medicaid funding.

In one example of how Medicaid impacts services offered, Thresholds, a Chicago area Medicaid-billing PSH provider, historically assisted their residents when they interact with justice or medical systems—traveling with them to appointments or court dates, and staying with them throughout—but has cut back because the time spent on those services is hard to justify to Medicaid. "We're less willing to sit with someone in a court, ER, doctor's office, et cetera," says Tim Devitt of Thresholds. "The reality is that some people don't stay [for their appointments] if we don't stay." And because Thresholds is certified to bill for mental health and substance use services, but not medical services, they cannot generally be reimbursed through Medicaid for helping residents manage their diabetes, for example, or reduce tobacco use unless they can relate it to a mental health need—a nuance that some staff members don't always capture when documenting their services. Thresholds also noted that the fact that they cannot bill Medicaid for outreach and engagement services is challenging for providers that work with homeless populations, which often

SERVICES OFFERED AT PSH PROVIDERS, BY MEDICAID BILLER STATUS

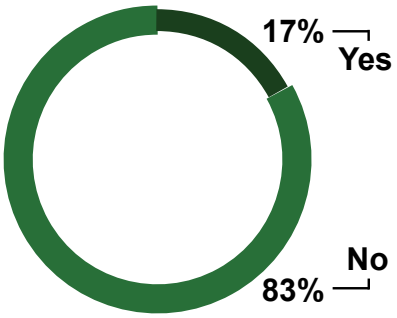
FIGURE 33 (N = 19)

	Medicaid-billing PSH provider (n=18)	Non-Medicaid-billing PSH provider (n=17)
Case management	94%	94%
Mental health services	89%	35%
Legal services	11%	29%
Child care	6%	29%
Clothing	39%	47%
Substance use services	61%	47%
Employment assistance	67%	77%
HIV/AIDS related services	17%	35%
Medication monitoring	78%	24%
Other health services	33%	29%
Education/vocational training	39%	35%
ESL classes	11%	12%
Transportation	67%	71%
Financial literacy	50%	77%
Primary care	33%	12%

take much legwork to reach.

PERCENT OF MEDICAID-BILLING PSH PROVIDERS THAT PARTNER WITH OTHER PSH PROVIDERS

FIGURE 34 (N = 18)

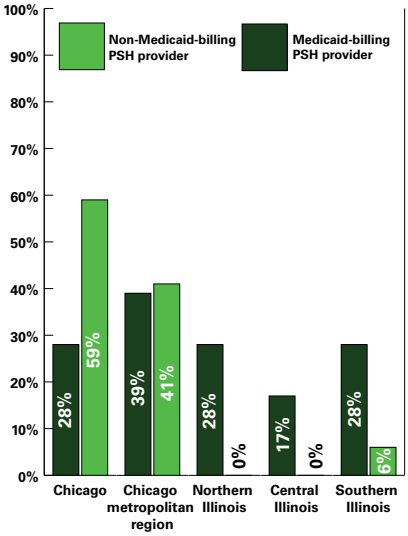


A small fraction of Medicaid billers (17 percent) partner with other PSH providers to provide Medicaid billable services on their sites (see fig. 34). These partnerships largely involve providing mental health and substance use services to the other PSH provider's tenants. All of the Medicaid billers felt that the partnership was beneficial to their organization because they can bill for new clients and PSH tenants receive services needed to help them remain healthy and housed.

Medicaid biller status varies by the PSH providers' geographic locations. This geographic variation may be due to different PSH business models throughout the state; downstate, many PSH providers are integrated in medical systems, while some PSH providers in Chicago are primarily property managers or place residents in scattered-site units. Non-billers are primarily in the Chicago area (59 percent of non-billers have units in Chicago and 41 percent have units in the Chicago metro area), while Medicaid billers are better represented throughout the state (28 percent of billers have units in Chicago, 39 percent in the Chicago metro area, 28 percent in Northern Illinois, 17 percent in Central Illinois, and 28 percent in Southern Illinois) (see fig. 35).

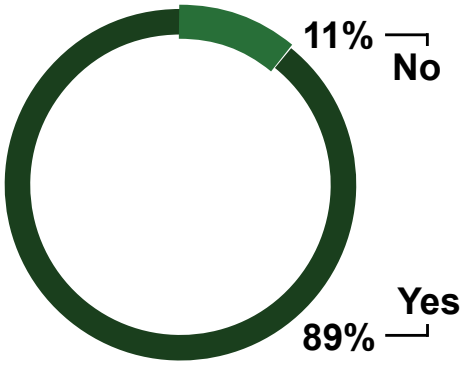
PSH PROVIDERS BY GEOGRAPHY AND MEDICAID BILLER STATUS

FIGURE 35 (N = 35)



PERCENT OF MEDICAID-BILLING PSH PROVIDERS THAT CONTRACT WITH MCOS

FIGURE 36 (N = 19)



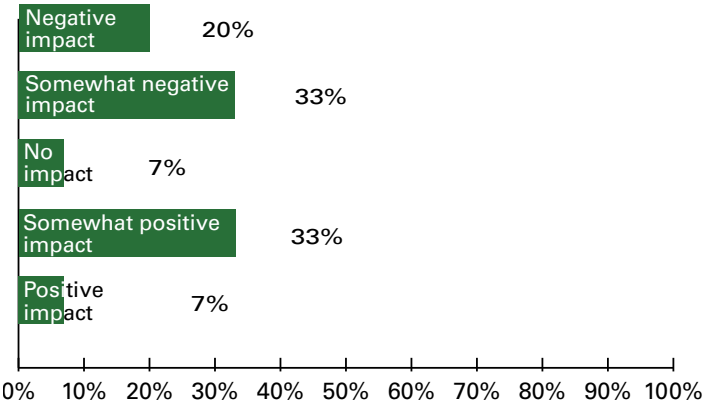
THE ROLE OF MANAGED CARE

Unsurprisingly—given that the majority of Medicaid members in Illinois are members of managed care organizations—most Medicaid-billing PSH providers contract with MCOs (89 percent) (see fig. 36). Over half (53 percent) of Medicaid billers that contract with MCOs find that the administrative impact of contracting with MCOs is negative or somewhat negative, while 40 percent find that it is somewhat positive or positive (see fig. 37).

In general, Medicaid-billing PSH providers found the financial benefits of contracting with MCOs were worth the costs. Medicaid-billing PSH providers that contract with MCOs often found that the personnel costs associated with contracting with MCOs were

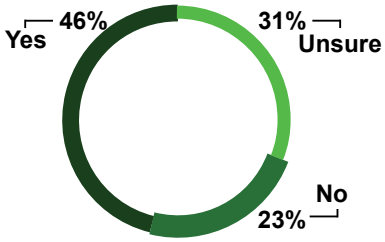
ADMINISTRATIVE IMPACT OF MCO CONTRACTING ON MEDICAID-BILLING PSH PROVIDERS

FIGURE 37 (N = 15)



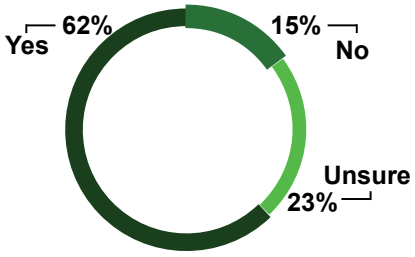
IF YOU HIRED NEW STAFF IN ORDER TO CONTRACT WITH AN MCO, HAVE THE PERSONNEL COSTS BEEN SUSTAINABLE OVER TIME?

FIGURE 38 (N = 13)



IF YOU MADE ADMINISTRATIVE CHANGES IN ORDER TO CONTRACT WITH AN MCO, HAVE THE COSTS BEEN SUSTAINABLE OVER TIME?

FIGURE 39 (N = 13)

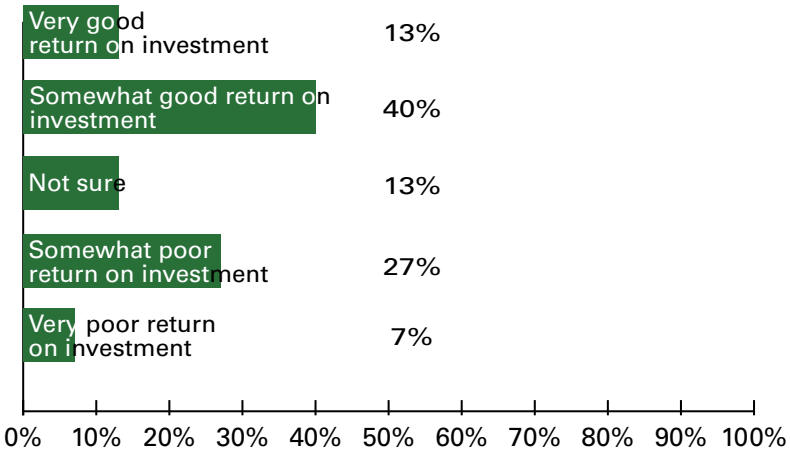


sustainable over time (46 percent), and 62 percent found that the administrative costs associated with contracting with MCOs were sustainable over time (see fig. 38 and 39). Over half of Medicaid-billing PSH providers that contract with MCOs (53 percent) feel that they receive a very good or somewhat good return on investment from contracting with MCOs, compared to 33 percent that feel that they receive a somewhat poor or very poor ROI (see fig. 40).

While managed care organizations are paid by the state via

RETURN ON INVESTMENT OF MCO CONTRACTING FOR MEDICAID-BILLING PSH PROVIDERS

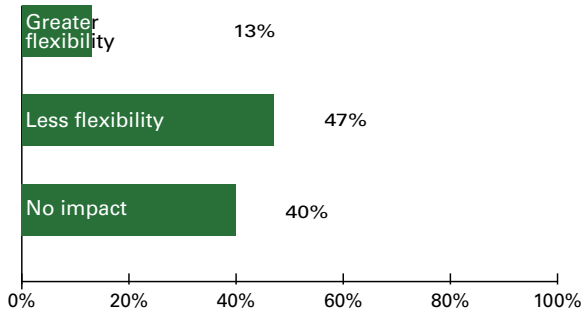
FIGURE 40 (N = 15)



capitated rates, MCOs in Illinois typically pay providers on a fee-for-service basis, which creates complex administrative burdens. Nearly half (47 percent) of Medicaid-billing PSH providers that contract with MCOs do not feel that their billing and reimbursement systems are an improvement over fee-for-service payments (only 27 percent do feel like it is an improvement) (see fig. 41). Nearly half of PSH providers that contract with an MCO say that their MCO contract provides them less flexibility to provide services, and another 40 percent say it has no impact on

IMPACT OF MCO CONTRACTS ON SERVICE DELIVERY

FIGURE 41 (N = 15)

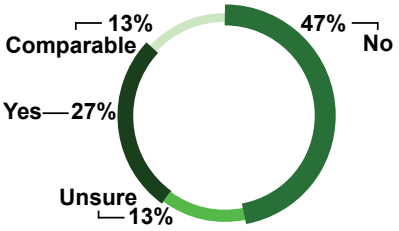


their ability to provide services (see fig. 42).

Another main benefit of managed care is that it is supposed to coordinate the patient's care across providers, reducing unnecessary treatments and missed opportunities. While the majority (53 percent) of Medicaid-billing PSH providers that contract with MCOs receive support from MCO care coordination staff, it is still concerning that a third of them do not receive this support when it is a central component of the managed care model (see fig. 43).

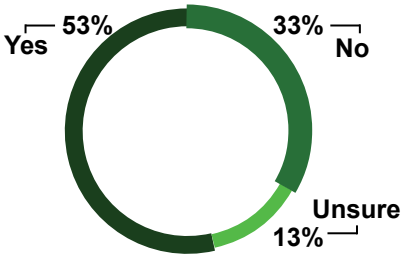
ARE MCOS' BILLING AND REIMBURSEMENT SYSTEMS AN IMPROVEMENT OVER MEDICAID FEE-FOR-SERVICE SYSTEMS?

FIGURE 42 (N = 15)



PERCENT OF PSH PROVIDERS WITH MCO CONTRACTS THAT GET SUPPORT FROM CARE COORDINATION STAFF

FIGURE 43 (N = 15)



IMPLICATIONS FOR POLICY AND PRACTICE

Changes in the policy landscape and the large proportion of providers reporting difficulties and confusion with administering Medicaid have important implications for PSH providers and policymakers. The trends that demonstrate a need for PSH providers to diversify their funding sources demand that both these stakeholder groups take action to ensure Illinois can leverage the opportunities and navigate the challenges that such a trend represents.

IMPLICATIONS FOR PSH PROVIDERS

Consider becoming a certified Medicaid provider

While becoming a certified Medicaid provider may not be the best course of action for all PSH providers, particularly under the current Illinois Medicaid benefits and rules, it is nonetheless critical that each provider carefully consider the option. Survey responses and interviewee comments both demonstrate some consensus that such consideration is vital. The complexities inherent in Medicaid provider certification make the need to start internal assessments and dialogues about this issue even more urgent. PSH providers should seek assistance in making this decision from other PSH providers who have gone through the process already, from the state, and from other organizations with experience in this area.

Explore partnerships with traditional health and behavioral health organizations

Regardless of a given organization's decision regarding becoming a Medicaid provider, closer ties with traditional health and behavioral healthcare providers would benefit those PSH providers that currently have weaker ties with such organizations. Survey responses indicate few partnerships between PSH providers and other healthcare providers, as well as fewer clinical services offered by PSH providers who are not Medicaid certified. It is likely that the residents of these programs have a variety of clinical service needs and closer integration of these services with the support services provided directly by the PSH organization could result in more effective service delivery overall. Partnerships with hospitals and safety net clinics might also develop into an arrangement that allows the PSH to access some Medicaid funding for their program, as demonstrated by the Health Neighborhoods project. Demonstrating the value of the PSH model to new organizations and possibly enlisting their resources in the effort to support the health and well-being of those experiencing housing instability could be an additional benefit to exploring such partnerships.

Invest in data systems

In order to partner with a Medicaid biller, or become Medicaid certified, PSH providers need to demonstrate that the supportive services they offer have a positive impact on residents' health outcomes. Many PSH providers do not have the data systems, policies and procedures, or data-driven culture in place to do so. PSH providers should investigate and implement technology and procedures in order to track client outcomes.

IMPLICATIONS FOR POLICYMAKERS AND MCOs

Reduce the challenges associated with becoming a certified Medicaid provider

A consistent theme throughout the responses from PSH providers was the difficulty and confusion of the Medicaid provider certification process. Some of these hurdles are unavoidable due to federal law and the need for program integrity, but many changes are still feasible. For instance, the separate enrollment, licensing, and certification processes required by HFS through its IMPACT system, DMH, and DASA are experienced as duplicative. The state could assist providers by seeking ways to share data across agencies and developing a centralized certification system that authorizes providers of most Medicaid services. The differing and rather specific staffing composition, facility licensure, and other criteria for Rule 132, 2060, and 2090 could also be simplified and standardized.

Another strategy to reducing the burdens of this process is for the state to provide more accessible and intensive support to interested community providers. The state may only be able to reduce complexity so much based on Medicaid requirements, but additional support would be a vital resource. This could include in-person technical assistance, webinars, model contracting language, other standardized protocols and guides, support of third-party technical assistance providers, or any number of other resources and supports.

Simplify billing and documentation requirements

The process to efficiently document, bill, and be reimbursed for Medicaid services is another set of challenges that appears to discourage PSH providers from participating in the Medicaid system. Greater clarity regarding the eligibility for services and the process to authorize them could make the process less daunting to some PSH providers. Standardization for billing directly to the state and to the various MCOs could also reduce the time and resources needed to obtain Medicaid reimbursement. A review of duplicative documentation requirements across eligible service categories and between providers and MCO assessments could also simplify this process.

Facilitate and incentivize innovative payment and delivery service models

Existing administrative rules and MCO contracts do little to allow PSH providers the flexibility to provide person-centered care and innovate in the delivery of services. All services must be authorized in advance through the complex and labor-intensive assessment and treatment planning process, forcing PSH providers to provide the services agreed to in advance in the plan rather than having the latitude to respond to resident needs as they arise. The allowable services themselves are also rather prescriptive and do not allow for all the supports a resident might need to remain stably housed.

A better approach would be to allow and incentivize daily or monthly case rate reimbursements for PSH providers supporting residents in supportive housing. Such 'capitated payments' are provided to a select few PSH providers through specialized MCO contracts, but current policies do not make such arrangements easy. Tying payment to outcomes, such as housing stability or reduced emergency department use, and allowing providers to support residents as needed could drive improvement, facilitate innovation, reduce administrative burdens, and lower costs, as demonstrated by evaluations of similar models across the country. The state should incentivize providers and MCOs to explore such arrangements through additional incentive payments or reductions in required documentation and data submission.

Pursue a new Medicaid supportive housing benefit

Perhaps the most important implication of this report is the need to broaden the services that are reimbursable under the Medicaid program. Thankfully, the state is already working with federal CMS on developing a Medicaid supportive housing benefit. The parameters of such a benefit, however, will have significant implications for its reach and impact on the sector and those Illinoisans needing PSH services.

The state has numerous Medicaid authorities and benefit designs it can choose from, but some principles to guide the establishment of the new benefit include:

- Provide an expansive set of pre-tenancy, tenancy, and planning/evaluation services that allows PSH providers the flexibility to support PSH residents in all the ways needed to remain stably housed, which is a key component of maintaining their health.
- Establish clear eligibility requirements for Medicaid beneficiaries, recognizing the cost savings and health benefits of supportive housing even for those without serious disabilities. Illinois's current focus with the IAP process of supporting pre-tenancy and tenancy support services for individuals moving out of institutions will restrict these supportive

services from many Medicaid beneficiaries who could significantly benefit from them.

- Structure reimbursement around a daily (or monthly) case rate to reduce the administrative burdens on PSH providers.
- Consider using quality metrics like reduced Emergency Room use to promote provider accountability rather than extensive documentation requirements.
- Facilitate innovative contracting arrangements with MCOs to reduce or eliminate the need for PSH providers to contract with numerous MCOs. The use of an intermediary entity that can contract with MCOs and subcontract with PSH providers is one model that can reduce the need for individual PSH providers to contract directly with all MCOs in their region.
- Evaluate savings generated from the new benefit and devote a portion of those savings to new affordable housing resources. Providing funding and assistance to PSH providers to implement the necessary data systems to track outcomes will be a key part of this process.
- Solicit input from the existing healthcare and PSH provider community and be responsive to such input in designing the benefit.
- Apply for the new benefit shortly after completion of the IAP to make new federal PSH resources available as soon as possible.

Adequately fund existing PSH funding streams

Medicaid payment rates for PSH services, as well as many other services, are near universally recognized as inadequate. They do not cover even the cost of care, much less providing any resources to expand or invest. A comprehensive rate review and requisite rate increases are desperately needed.

In addition, supportive grants funded by the State need to be maintained and funded through a comprehensive state budget. These grants will continue to be necessary in spite of any new Medicaid resources as certain needed services are unlikely to be eligible for Medicaid reimbursement, at least in the near term. The state should reinvest in these grants, particularly to support continued PSH operations while the sector attempts to make the difficult transition to more Medicaid financed services.

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

WHY HAVE YOU DECIDED NOT TO PURSUE ENROLLING AS A MEDICAID PROVIDER?

TABLE A.1

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider	Considered both options (n=6)	Not Considered Enrolling
The requirements for becoming a Medicaid provider are unclear	50%	-	33%	-
We would have to hire staff members with high salaries, such as licensed clinical professionals, in order to become a Medicaid provider	25%	-	33%	-
The administrative burdens of billing Medicaid are too high	25%	-	50%	-
We would need expensive new IT software	25%	-	17%	-
We would need to purchase mal-practice or other insurance	0%	-	33%	-
We are not interested in providing Medicaid billable services on our site	0%	-	0%	-
We do not believe our residents would benefit from enough Medicaid billable services to make the investment worth it	0%	-	17%	-
We heard that the online enrollment system for Medicaid providers is not working	0%	-	0%	-
We are interested in enrolling as a Medicaid provider but have not done so yet	0%	-	17%	-
We are in the process of enrolling as a Medicaid provider but have not completed it yet	50%	-	0%	-
Other	0%	-	33%	-

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

WHY HAVE YOU DECIDED NOT TO PURSUE PARTNERING WITH A MEDICAID PROVIDER?

TABLE A.2

	Considered Enrolling as a Provider	Considered Partnering with a Provider (n=3)	Considered both options (n=6)	Not Considered Enrolling
I do not know of any Medicaid providers that would be willing to partner with us	-	0%	0%	-
I am unsure of what changes I would have to make to my staff or organization in order to embark on a partnership	-	0%	50%	-
I am unsure whether a partnership would result in increased revenue for my organization	-	0%	67%	-
We are not interested in providing Medicaid billable services on our site	-	0%	0%	-
We do not believe our residents would benefit from enough Medicaid billable services to make the investment worth it	-	0%	0%	-
We are interested in partnering with a Medicaid provider but have not done so yet	-	0%	0%	-
We are in the process of creating a partnership with a Medicaid provider but have not completed it yet	-	67%	17%	-
Other	-	33%	17%	-

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

IF YOU ARE PLANNING TO BECOME CERTIFIED, FOR WHICH PROGRAM(S) ARE YOU PLANNING TO BECOME CERTIFIED OR ARE IN THE PROCESS OF BECOMING CERTIFIED?

TABLE A.3

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=2)		(n=1)	
Medical Program	0%	-	0%	-
Mental Health Rehabilitation Option (Rule 132: Medicaid Community Mental Health Program)	50%	-	50%	-
Alcoholism and Substance Abuse Services (Rule 2090, Subacute Alcoholism and Substance Abuse Treatment Services)	100%	-	50%	-
Home and Community-Based Services Waiver	0%	-	0%	-
Children that are Technology Dependent/Medically Fragile	0%	-	0%	-
Persons with Disabilities	0%	-	0%	-
Persons with Brain Injuries	0%	-	0%	-
Adults with Developmental Disabilities	0%	-	0%	-
Persons who are Elderly	0%	-	0%	-
Persons with HIV or AIDS	0%	-	0%	-
Supportive Living Facilities	50%	-	50%	-

DID YOU RECONSIDER ENROLLING AS A MEDICAID PROVIDER AFTER THE EXPANSION OF MEDICAID ELIGIBILITY UNDER THE AFFORDABLE CARE ACT?

TABLE A.4

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=4)		(n=6)	
Yes	50%	-	83%	-
No	0%	-	0%	-
Not sure	50%	-	17%	-

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

WHEN CONSIDERING WHETHER TO ENROLL AS A MEDICAID PROVIDER, DID YOU LOOK INTO THE REQUIREMENTS FOR CONTRACTING WITH AN MCO?

TABLE A.5

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider	Considered both options (n=6)	Not Considered Enrolling
Yes	25%	-	17%	-
No	50%	-	50%	-
Not sure	25%	-	33%	-

DID ANY OF THE FOLLOWING BARRIERS TO CONTRACTING WITH AN MCO INFLUENCE YOUR DECISION NOT TO ENROLL AS A MEDICAID PROVIDER?

TABLE A.6

	Considered Enrolling as a Provider (n=1)	Considered Partnering with a Provider	Considered both options (n=1)	Not Considered Enrolling	Currently a Provider (n=2)
MCO requirements are more stringent than Medicaid's and we cannot/do not want to meet them	100%	-	0%	-	0%
The reimbursement process with MCOs is too cumbersome	0%	-	0%	-	0%
There are few or no MCOs in my region	0%	-	0%	-	0%
I do not know how to start the process of contracting with an MCO	0%	-	0%	-	0%
My clients/tenants are not required to use an MCO to access Medicaid services	0%	-	0%	-	0%
MCOs do not understand how to work with PSH providers	0%	-	0%	-	0%
MCOs are not interested in contracting with my organization	0%	-	0%	-	0%
None of these barriers to contracting with an MCO affected my decision to enroll as a Medicaid provider	0%	-	100%	-	0%
Other	0%	-	0%	-	100%

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

ARE YOU FAMILIAR WITH THE ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' NEW ONLINE ENROLLMENT SYSTEM FOR MEDICAID PROVIDERS, CALLED IMPACT?

TABLE A.7

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=4)	(n=4)	(n=6)	(n=7)
Yes	50%	50%	0%	0%
No	50%	50%	100%	100%
Not sure	0%	0%	0%	0%

HAVE YOU HEARD OF ANY POSITIVE OR NEGATIVE EXPERIENCES THAT COLLEAGUES AT MEDICAID PROVIDERS HAD WHILE USING IMPACT?

TABLE A.8

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=2)	9n=2)		
I have heard that my colleagues generally had positive experiences enrolling as Medicaid providers in IMPACT	0%	0%	-	-
I have heard that my colleagues generally had negative experiences enrolling as Medicaid providers in IMPACT	0%	50%	-	-
I have heard that my colleagues had mixed experiences enrolling as Medicaid providers in IMPACT	0%	50%	-	-
I have not heard about my colleagues' experiences using IMPACT	100%	0%	-	-

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

DO THE ADMINISTRATIVE REQUIREMENTS ASSOCIATED WITH BILLING FOR MEDICAID SERVICES AFFECT YOUR DECISION ABOUT ENROLLING AS A MEDICAID PROVIDER?

TABLE A.9

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=4)	(n=4)	(n=6)	(n=7)
Yes	50%	75%	50%	43%
No	50%	0%	0%	14%
Not sure	0%	25%	50%	43%

PLEASE SELECT THE CONCERNS YOU HAVE ABOUT THE ADMINISTRATIVE IMPACT OF MEDICAID ON YOUR ORGANIZATION.

TABLE A.10

	Considered Enrolling as a Provider	Considered Partnering with a Provider	Considered both options	Not Considered Enrolling
	(n=2)	(n=3)	(n=3)	(n=3)
I do not have the technological capacity to bill for services in the way that Medicaid requires.	100%	100%	100%	67%
I do not have the staff capacity to bill for services in the way that Medicaid requires.	100%	100%	100%	100%
I am concerned about the record-keeping and auditing that Medicaid requires.	-	67%	100%	67%
I am concerned that the administrative requirements would limit my ability to deliver services.	50%	67%	100%	100%
Other	0%	33%	0%	0%

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

HAVE YOU HEARD ABOUT THE EXPERIENCES OF OTHER PSH PROVIDERS THAT ARE CERTIFIED AS MEDICAID PROVIDERS OR PARTNER WITH MEDICAID PROVIDERS?

TABLE A.11

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider (n=4)	Considered both options (n=6)	Not Considered Enrolling (n=7)
Yes, I have generally heard that other PSH providers have positive experiences with Medicaid.	0%	0%	0%	0%
Yes, I have generally heard that other PSH providers have negative experiences with Medicaid.	25%	0%	33%	0%
Yes, I have heard that other PSH providers have mixed experiences with Medicaid.	25%	75%	33%	43%
No, I have not heard about the experiences of other PSH providers with Medicaid.	50%	25%	33%	57%

HAS HEARING ABOUT OTHER PSH PROVIDERS' EXPERIENCES WITH MEDICAID MADE YOU MORE LIKELY, LESS LIKELY, OR EQUALLY LIKELY TO DECIDE TO BECOME A MEDICAID PROVIDER OR PARTNER WITH ONE?

TABLE A.12

	Considered Enrolling as a Provider (n=2)	Considered Partnering with a Provider (n=3)	Considered both options (n=4)	Not Considered Enrolling (n=1)
More likely to become a Medicaid provider or partner with one	0%	0%	50%	100%
Less likely to become a Medicaid provider or partner with one	0%	0%	25%	0%
Equally likely to become a Medicaid provider or partner with one	100%	100%	25%	0%

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

DO YOU THINK YOUR TENANTS WOULD BENEFIT FROM MEDICAID BILLABLE SERVICES IF YOU WERE ABLE TO PROVIDE THEM?

TABLE A.13

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider (n=4)	Considered both options	Not Considered Enrolling (n=7)
Yes	75%	50%	-	43%
No	0%	0%	-	0%
Not sure	25%	50%	-	57%

WHICH PROGRAMS DO YOU THINK YOUR TENANTS WOULD BE ELIGIBLE FOR AND BENEFIT FROM? SELECT ALL THAT APPLY.

TABLE A.14

	Considered Enrolling as a Provider (n=3)	Considered Partnering with a Provider (n=2)	Considered both options	Not Considered Enrolling (n=3)
Medical Program	67%	0%	-	67%
Mental Health Rehabilitation Option (Rule 132: Medicaid Community Mental Health Program)	0%	100%	-	100%
Alcoholism and Substance Abuse Services (Rule 2090, Subacute Alcoholism and Substance Abuse Treatment Services)	67%	100%	-	100%
Home and Community-Based Services Waiver	33%	50%	-	33%
Children that are Technology Dependent/Medically Fragile	0%	0%	-	0%
Persons with Disabilities	33%	50%	-	67%
Persons with Brain Injuries	0%	0%	-	0%
Adults with Developmental Disabilities	0%	0%	-	0%
Persons who are Elderly	33%	0%	-	33%
Persons with HIV or AIDS	33%	50%	-	67%
Supportive Living Facilities	33%	0%	-	0%

APPENDIX A: SURVEY RESPONSES FOR NON-MEDICAID-BILLING PSH PROVIDERS

IF A MEDICAID PROVIDER APPROACHED YOUR ORGANIZATION ABOUT PARTNERING TO PROVIDE MEDICAID BILLABLE SERVICES ON YOUR SITE, WOULD THAT INTEREST YOU?

TABLE A.26

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider (n=4)	Considered both options	Not Considered Enrolling (n=7)
Yes	50%	50%	-	43%
	25%	50%	-	0%
Not sure	25%	0%	-	57%

DO YOU THINK YOUR ORGANIZATION WILL ENROLL AS A MEDICAID PROVIDER OR PARTNER WITH ONE IN THE FUTURE?

TABLE A.27

	Considered Enrolling as a Provider (n=4)	Considered Partnering with a Provider (n=4)	Considered both options	Not Considered Enrolling (n=7)
Yes, we will likely enroll as a Medicaid provider	100%	50%	-	14%
Yes, we will likely partner with a Medicaid provider	25%	50%	-	0%
No	100%	0%	-	0%
Unsure	0%	25%	-	100%

APPENDIX B: SURVEY RESPONSES FOR MEDICAID-BILLING PSH PROVIDERS

HOW MANY PEOPLE ON YOUR STAFF WERE ACTIVELY INVOLVED WITH THE PROCESS OF ENROLLING AS A MEDICAID PROVIDER?

TABLE A.15

	Currently a Provider (n=17)
1 - 2	35%
3 - 4	6%
5 or more	29%
Do not know	29%

WHAT WOULD YOU ESTIMATE WAS THE NUMBER OF HOURS YOUR STAFF COMMITTED TO THE PROCESS OF ENROLLING AS A MEDICAID PROVIDER?

TABLE A.16

	Currently a Provider (n=13)
0 to 50 hrs	77%
51 to 100 hrs	8%
101 hrs or more	15%

IF YOU RECEIVED TRAINING/ASSISTANCE WITH THE MEDICAID ENROLLMENT PROCESS, WHO PROVIDED THE TRAINING/ASSISTANCE?

TABLE A.17

	Currently a Provider (n=6)
Illinois Department of Healthcare and Family Services	50%
Center for Medicare & Medicaid Services	17%
Corporation for Supportive Housing	17%
Supportive Housing Providers Association	17%
Other	50%

APPENDIX B: SURVEY RESPONSES FOR MEDICAID-BILLING PSH PROVIDERS

IF YOU RECEIVED TRAINING/ASSISTANCE WITH THE MEDICAID ENROLLMENT PROCESS, IN WHAT FORMAT DID YOU RECEIVE THE TRAINING/ASSISTANCE?

TABLE A.18

	Currently a Provider (n=6)
Webinar/conference call	33%
Online materials	33%
In-person training	50%
Other	50%

HOW MANY PEOPLE ON YOUR STAFF WERE ACTIVELY INVOLVED WITH THE PROCESS OF CONTRACTING WITH AN MCO?

TABLE A.19

	Currently a Provider (n=16)
1 - 2	38%
3 - 4	50%
5 or more	13%

WHAT WOULD YOU ESTIMATE WAS THE NUMBER OF HOURS YOUR STAFF COMMITTED TO THE PROCESS OF CONTRACTING WITH AN MCO?

TABLE A.20

	Currently a Provider (n=13)
0 to 50 hrs	77%
51 to 100 hrs	8%
101 hrs or more	15%

APPENDIX B: SURVEY RESPONSES FOR MEDICAID-BILLING PSH PROVIDERS

BRIEFLY DESCRIBE WHAT BARRIERS YOU FACED WHEN TRYING TO ENROLL AS A MEDICAID PROVIDER USING IMPACT.

TABLE A.21

	Currently a Provider (n=4)
Technological issues	50%
Incorrect certification number	50%

IF YOU RECEIVED TRAINING/ASSISTANCE ON IMPACT, IN WHAT FORMAT DID YOU RECEIVE THE TRAINING/ASSISTANCE?

TABLE A.22

	Currently a Provider (n=11)
Webinar/conference call	91%
Online materials	36%
In-person training	0%
Other	9%

IF YOU RECEIVED TRAINING/ASSISTANCE ON IMPACT, IN WHAT FORMAT DID YOU RECEIVE THE TRAINING/ASSISTANCE?

TABLE A.23

	Currently a Provider (n=11)
Illinois Department of Healthcare and Family Services (including DASA or DMH)	100%
Center for Medicare & Medicaid Services	0%
Corporation for Supportive Housing	0%
Supportive Housing Providers Association	0%
Other	0%

APPENDIX B: SURVEY RESPONSES FOR MEDICAID-BILLING PSH PROVIDERS

IF YOU PARTNER WITH A PSH PROVIDER TO PROVIDE MEDICAID-BILLABLE SERVICES TO THEIR RESIDENTS, UNDER WHAT PROGRAMS ARE MEDICAID SERVICES PROVIDED THROUGH THIS PARTNERSHIP?

TABLE A.24

	Currently a Provider (n=3)
Medical Program	33%
Mental Health Rehabilitation Option (Rule 132: Medicaid Community Mental Health Program)	100%
Alcoholism and Substance Abuse Services (Rule 2090, Subacute Alcoholism and Substance Abuse Treatment Services)	100%
Home and Community-Based Services Waiver	33%
Children that are Technology Dependent/Medically Fragile	0%
Persons with Disabilities	33%
Persons with Brain Injuries	0%
Adults with Developmental Disabilities	33%
Persons who are Elderly	33%
Persons with HIV or AIDS	0%
Supportive Living Facilities	0%

APPENDIX B: SURVEY RESPONSES FOR MEDICAID-BILLING PSH PROVIDERS

HAS ENROLLING AS A MEDICAID PROVIDER ALLOWED YOUR ORGANIZATION TO PROVIDE NEW SERVICES THAT IT DID NOT PROVIDE PRIOR TO BECOMING A MEDICAID PROVIDER?

TABLE A.25

	Currently a Provider (n=17)
Yes	29%
No	41%
Not sure	6%
My organization became certified as a Medicaid provider long ago	24%

IF YOU ARE ABLE TO OFFER NEW SERVICES, UNDER WHICH PROGRAMS ARE YOU NOW ABLE TO BILL MEDICAID FOR NEW SERVICES THAT YOU PROVIDE?

TABLE A.26

	Currently a Provider (n=5)
Medical Program	0%
Mental Health Rehabilitation Option (Rule 132: Medicaid Community Mental Health Program)	40%
Alcoholism and Substance Abuse Services (Rule 2090, Subacute Alcoholism and Substance Abuse Treatment Services)	40%
Home and Community-Based Services Waiver	0%
Children that are Technology Dependent/Medically Fragile	0%
Persons with Disabilities	0%
Persons with Brain Injuries	0%
Adults with Developmental Disabilities	20%
Persons who are Elderly	0%
Persons with HIV or AIDS	0%
Supportive Living Facilities	0%
My organization became certified as a Medicaid provider long ago	0%

APPENDIX C: SURVEY RESPONSES FOR ALL PSH PROVIDERS

WHICH OF THE FOLLOWING STATEMENTS APPLY TO YOUR ORGANIZATION AND SEEM TO BE BARRIERS TO BECOMING CERTIFIED AS A MEDICAID PROVIDER?

TABLE A.27

	Considered Enrolling as a Provider (n=2)	Considered Partnering with a Provider (n=4)	Considered both options (n=6)	Not Considered Enrolling (n=7)	Currently a Provider (n=14)
My organization does not have internet access	0%	0%	0%	0%	0%
Not all staff members within my organization have email capability	0%	0%	0%	0%	0%
My organization does not currently use an electronic billing system	100%	50%	67%	57%	7%
My organization does not currently have the capacity to measure the success of services we provide	0%	0%	0%	14%	0%
My organization does not document services in an electronic resident/client record	50%	25%	17%	14%	21%
None of the above	0%	0%	17%	29%	64%
Other	0%	50%	0%	29%	14%

HOW HAS YOUR FUNDING BEEN IMPACTED BY THE BUDGET STANDOFF IN SPRINGFIELD?

TABLE A.28

Impact of the budget standoff (n=37)	
Reduce staff	76%
Reduce client caseload	30%
Close locations/reduce number of units	22%
Reduce services provided	70%
Increase waiting list	38%
Change services provided	30%
Reduce staff salaries/benefits	27%
Skip payroll	8%
Tap into cash reserves	68%
Tap into lines of credit	30%
My funding has not been impacted by the budget standoff in Springfield	0%
My funding has been impacted by the budget standoff in Springfield in other ways	22%

APPENDIX C: SURVEY RESPONSES FOR ALL PSH PROVIDERS

WHAT IS THE AMOUNT OF YOUR ANNUAL BUDGET?

TABLE A.29

Budget (n=35)	
under $1,000,000	11%
$1,000,001 to $5,000,000	54%
$5,000,001 to $10,000,000	9%
$10,000,001 to $20,000,000	3%
$20,000,001 to $30,000,000	11%
$30,000,001 to $40,000,000	3%
$40,000,001 to $50,000,000	6%
$50,000,001 to $60,000,000	0%
$60,000,001 to $70,000,000	3%

HOW MANY PSH UNITS DOES YOUR ORGANIZATION MANAGE?

TABLE A.31

PSH units (n=37)	
0 to 50	41%
51 to 100	11%
101 to 150	16%
151 to 200	3%
201 to 250	19%
251 to 300	0%
301 to 350	0%
351 to 400	3%
401 to 450	0%
451 to 500	3%
501 to 550	5%

HOW MANY FULL TIME STAFF DOES YOUR AGENCY EMPLOY?

TABLE A.30

Staff (n=37)	
0 to 50	54%
51 to 100	14%
101 to 200	11%
201 to 300	3%
301 to 400	0%
401 to 500	8%
501 to 600	0%
601 to 700	3%
701 to 800	3%
801 to 900	0%
901 to 1000	3%
1001 or more	3%

WHAT KIND OF PERMANENT SUPPORTIVE HOUSING DO YOU OFFER?

TABLE A.32

PSH units (n=37)	
Single-site housing	54%
Scattered-site housing	68%
Other	19%

APPENDIX C: SURVEY RESPONSES FOR ALL PSH PROVIDERS

IS YOUR ORGANIZATION ACCREDITED?

TABLE A.33

Accreditation (n=36)	
Yes	47%
No	44%
Planning to add accreditation within one year	3%
Planning to add accreditation in the future but more than a year away	6%

WHERE IN THE STATE OF ILLINOIS DO YOU HAVE PSH PROGRAMS?

TABLE A.34

Locations (n=35)	
City of Chicago	43%
Chicago metropolitan region	40%
Northern Illinois	14%
Central Illinois	9%
Southern Illinois	17%

WHICH NATIONAL ORGANIZATION PROVIDES YOUR ACCREDITATION?

TABLE A.35

Organizations providing accreditation (n=17)	
Commission on Accreditation of Rehabilitation Facilities (CARF)	53%
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	24%
The Council on Quality and Leadership (The Council) (TC)	6%
Council on Accreditation of Services for Families and Children (COA)	18%

DOES YOUR SUPPORTIVE HOUSING SERVE ALL PEOPLE WHO ARE HOMELESS/AT RISK OF HOMELESSNESS OR DO YOU TARGET A POPULATION WITH SPECIFIC NEEDS?

TABLE A.36

Population Served (n=26)	
All people who are homeless/at risk of homelessness are eligible for our supportive housing	54%
Specific population(s) of people who have special needs are eligible for our supportive housing	65%

APPENDIX C: SURVEY RESPONSES FOR ALL PSH PROVIDERS

PLEASE FILL OUT INFORMATION ON THE POPULATION SERVED IN YOUR SUPPORTIVE HOUSING PROJECT IN THE TABLE BELOW:

TABLE A.37

Population Served (n=27)	
Have a mental illness	93%
Homeless	78%
Alcohol users	67%
Dually diagnosed	67%
Drug users	59%
Have chronic physical health issues	59%
LGBT	52%
Victims of domestic violence	48%
Formerly incarcerated	48%
Have HIV/AIDS or related diseases	44%
Veterans	44%
Have developmental disabilities	41%
Have physical disabilities	37%
At risk of homelessness	15%
Pregnant/parenting teens	15%
Unaccompanied youth	15%
Other	11%

ESTIMATE THE PERCENT OF UNITS OCCUPIED BY THIS POPULATION

TABLE A.38

Average units occupied	
Have a mental illness (n=20)	92%
Homeless (n=22)	99%
Alcohol users (n=14)	55%
Dually diagnosed (n=12)	41%
Drug users (n=12)	60%
Have chronic physical health issues (n=12)	86%
LGBT (n=9)	27%
Victims of domestic violence (n=0)	0%
Formerly incarcerated (n=9)	47%
Have HIV/AIDS or related diseases (n=10)	24%
Veterans (n=9)	25%
Have developmental disabilities (n=8)	11%
Have physical disabilities (n=7)	74%
At risk of homelessness (n=3)	38%
Pregnant/parenting teens (n=4)	38%
Unaccompanied youth (n=4)	38%
Other (n=2)	54%

APPENDIX C: SURVEY RESPONSES FOR ALL PSH PROVIDERS

DOES YOUR ORGANIZATION EMPLOY ANY OF THE FOLLOWING PROFESSIONAL STAFF?

TABLE A.39

Professional Staff (n=37)	
Physician	16%
Psychiatrist	32%
Psychologist	16%
Master of Social Work	86%
Licensed Clinical Social Worker	65%
Licensed Clinical Professional Counselor	59%
Nursing Degree – RN	43%
Nursing Degree – APN	22%
Case Management	92%
Certified Alcohol Drug Counselor	62%
Vocational Rehabilitation	22%
Peer Counselor	41%
None of the Above	3%
Other	14%

DO YOU HAVE ANY LINKAGE AGREEMENTS OR OTHER ARRANGEMENTS WITH ORGANIZATIONS OR PROVIDERS WHO EMPLOY THE FOLLOWING PROFESSIONAL STAFF?

TABLE A.40

Linkage agreements (n=32)	
Physician	56%
Psychiatrist	59%
Psychologist	31%
Master of Social Work	38%
Licensed Clinical Social Worker	44%
Licensed Clinical Professional Counselor	41%
Nursing Degree – RN	38%
Nursing Degree – APN	34%
Case Management	28%
Certified Alcohol Drug Counselor	50%
Vocational Rehabilitation	28%
Peer Counselor	22%
None of the Above	3%
Other	6%

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